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Dermatological Section.

December 17, 1914.

Dr. J. Herbert Stowers, Vice-President of the Section, in the Chair.

Case of Angiokeratoma.

By W. Knowsley Sibley, M.D.

The patient was a girl, aged 17, engaged in housework, whose mother is stated to have died of cancer at the age of 46; her father was also dead, cause unknown. There were five brothers and sisters, all of whom were perfectly healthy.

The patient had had an eruption on the backs of the hands for seven years, getting gradually worse every winter and remaining more or less stationary through the summer months. Recently the lesions had become distinctly more marked and a few papules had appeared on the dorsum of some of the toes, and on the heels. The patient had a "chilblain circulation," but stated that she had never suffered from chilblains. The hands and fingers were enlarged and cyanosed. She had always perspired freely over the whole body, especially on the palms, which were often very damp. The patient stated that there was no pain or irritation, but the lesions easily bled if knocked. The eruption was present on the dorsum of all the fingers and both thumbs and over the knuckles, and consisted of small red, pale papules arranged more or less in groups, many of which had become flat and somewhat hard to the touch. White blisters, varying in size from a pin's head to a pea, were scattered about, and occurred especially on the sides of the hands, and of the index and little fingers. Indefinite lesions were scattered about the palms, chiefly of a dysidrotic nature. Small similar

lesions were present on the dorsa of the great toes and over the Achilles tendons.

A biopsy of one of the papules on the back of the hand gave the following histological condition: The primary pathological change seen in the section was a marked dilatation of all the blood-vessels, together with hypertrophy of the stratum corneum. There was a large space present in the papillary portion of the derma, which contained red blood corpuscles and a little fibrous tissue. There was also a dilatation of the lymph spaces, and a slight inflammatory condition of the upper portion of the dermis.

Showing cavernous space containing red and white blood cells and fibrous tissue; dilated blood-vessels and hypertrophy of the corneous layer. (× 100.)

The patient had been kept in bed with the hands covered up with cotton-wool, after being smeared over with calamine lotion, and a considerable improvement in the general condition had taken place. A pill containing 1 gr. of permanganate of potash taken three times a day, immediately after food, had diminished the general and also the ocal hyperidrosis.

DISCUSSION.

Dr. WHITFIELD said the section did not display the ordinary histological appearances of angiokeratoma; it was manifestly that of a mid-epidermic vesicle, whereas angiokeratoma was not a vesicle at any time. It appeared to be an instance of the condition on which the late Radcliffe Crocker wrote an article, in which he called it "a winter eruption."[1] The essence of it was cyanosis, a chilblain circulation, and deeply seated vesicles which often, when they burst, left superficial ulcers. He did not know that the pathology of the disease had been worked out, but many cases of it had been shown. The case exhibited did not show either warts or telangiectases; the lesions were not angiomatous, and they were not keratomata. The microscopical appearances of angiokeratoma were more like those of a cutaneous wart.

The CHAIRMAN (Dr. J. Herbert Stowers) asked whether the exhibitor considered that the photograph submitted included typical lesions of the disease in question and also whether he had seen the excellent coloured plates published together with a series of articles on "angiokeratoma" by Dr. Pringle, in the *British Journal of Dermatology*.[2] As the views of the case on the part of members generally differed from that of the exhibitor, he invited Dr. Sibley to show the patient again at a future meeting. It was certain that the dysidrosis presented by the patient was particularly noticeable.

Dr. ADAMSON also disagreed with Dr. Sibley's diagnosis; he saw no reason for calling it angiokeratoma, either clinically or histologically. There were none of the appearances characteristic of angiokeratoma of Mibelli and Pringle. He regarded the case as one of hyperidrosis with associated cheiropompholyx. The lesions present were vesicles. The cavity in the epidermis shown in the microscopical section was a vesicle, and not a dilated blood-vessel.

Mr. H. C. SAMUEL asked whether the patient's hyperidrosis was as bad in the summer as at present.

Dr. SIBLEY replied that the section was taken from the back of the knuckles; the lesion, which was a cavernous space, had its seat in the papillary layer and contained both fibrous tissue and red blood cells. The condition at present had more of the angiomatous than of the keratomatous element. The lesions had never broken down and ulcerated. There was a marked dilatation of lymph spaces and blood-vessels deeper down. He remembered Dr. Pringle's articles quite well.

[1] *Brit. Journ. Derm.*, 1900, xii, p. 42.

[2] *Brit. Journ. Derm.*, 1891, iii, pp. 237, 282, 309.

Case of Erythema Pernio; (?) Lupus Erythematosus.

By W. Knowsley Sibley, M.D.

The patient was a girl, aged 16, a dressmaker by occupation. The father was living and well, the mother suffered from asthma, bronchitis and rheumatism. She had had scarlet fever, measles and whooping-cough, and occasionally complained of muscular rheumatism. She stated that she never suffered from chilblains, but her fingers and hands were always cold to the touch. The eruption had been present on the left hand each winter for the last four years. It was entirely absent during the summer months and generally reappeared towards the end of September of each year. In her previous attacks the disease had always been confined to the left hand; but in the last five weeks it had also attacked the right hand slightly. The eruption was present on the dorsum of the fingers of the left hand and consisted of an erythematous condition with small papules, some of which were isolated and others grouped. Some of the lesions towards the finger-tips were superficially ulcerated and slight scarring was present. On the right hand the eruption was limited to smaller but similar lesions. The palms were unaffected. No lesions were present about the face, ears, or feet. Ecchymoses on various parts were apt to appear from time to time from no apparent cause.

DISCUSSION.

Dr. Graham Little regarded the case as a perfectly straightforward example of lupus erythematosus, and did not understand why it had been shown under other designation. Chilblain circulation was commonly present in such cases of lupus erythematosus, and its presence did not justify the classification with lupus pernio.

The Chairman considered that the diagnosis of the case as one of lupus erythematosus was undoubtedly correct.

Dr. Dore also regarded the case as a typical one of lupus erythematosus. In some of the text-books lupus pernio was classed with lupus erythematosus, but it was probably more closely allied to lupus vulgaris. In the case of the Belgian boy shown at the last meeting by Dr. Abraham, Dr. Pringle had pointed out that there were lupus nodules associated with the erythema.

Mr. McDonagh considered the case to be a lupus erythematosus. There were one or two interesting points which occurred to him, and which he thought should be borne in mind in connexion with it. The patient was a girl, and the condition was becoming worse. Many of the disappearing lesions had left scars, there were telangiectases above the affected parts, and both hands were involved. He therefore thought the patient might easily get very much worse, develop acute generalised lupus erythematosus, and die of an acute pneumococcal or of a tubercular infection. Three of the cases of acute lupus erythematosus which he had seen commenced in this way, and all the patients were girls.

Mr. H. C. Samuel said there were hæmorrhages in the skin, and often in cases of chilblains there was a diminished coagulability of the blood. It would be interesting to know what the coagulation time was in the patient exhibited.

Dr. Whitfield pointed out that the coagulation time would not be of any value in diagnosis, because the coagulation time in lupus erythematosus was also slow.

Dr. Sibley replied that when he first saw the case he regarded it as a lupus erythematosus; but when he learned that it completely disappeared in the summer, and that she had little ulcerations at the finger-tips, he thought uncomplicated lupus erythematosus would not act in that way. The fact that it was asymmetrical was much against it being chilblains. The backs of the fingers seemed typical of erythematosus. He had not seen the patient in the summer, but considered it a mixed case.

Case for Diagnosis; Persistent Nodular Erythema Multiforme.

By Henry MacCormac, M.B.

The patient, a woman, aged 64, stated that the condition began six months previously on the left foot as a "sore"; it had then spread to the hands, knees, elbows, &c., and now showed a well-marked symmetrical and bilateral distribution, especially tending to be present on points of pressure. The eruption, which was very nodular in its final stages, apparently began as a small flat lesion tending to enlarge, while clearing up in the centre, so that an area from a sixpence to a half-crown in size could be observed with a definitely raised margin of similar colour to that of normal skin. On the knees, elbows, knuckles, and on

the ear and nostril the lesions were of a purple tint, and here a superficial central necrosis occurred. There was a tendency to spontaneous resolution especially during rest in bed without any resulting scar. The family history was good; but one son was suffering from pulmonary tuberculosis. The Wassermann reaction was negative. Sections showed areas of cell infiltration with many polymorphonuclear leucocytes, but plasma cells and other round cells were also present. There were no giant cells. These appearances quite negatived the original diagnosis of a tuberculide.

Dr. MacCormac regarded it as a toxic eruption, and the microscopic sections supported that view.

DISCUSSION.

Dr. ADAMSON said that the case was, in his opinion, one of erythema multiforme of persistent type. Several similar cases had been shown at the Section meetings during the past two or three years. The first one he could recall was exhibited by Dr. Little[1] as a "case for diagnosis," and the speaker had then suggested the diagnosis of "erythema multiforme" with all its features exaggerated. Dr. Little's case was shown again some months later,[2] with the condition persisting unaltered. Dr. Gray had brought forward another case[3] (in May, 1913) with the diagnosis "persistent erythematous eruption," and Dr. Sequeira a third case,[4] also last year, as lichen verrucosus, which the speaker believed belong to the same class. In these three cases, as in that now shown by Dr. MacCormac, the lesions consisted of persistent raised, circular plaques or rings symmetrically distributed in the situations affected by the eruption of erythema multiforme—backs of hands and forearms and elbows and knees—and in Dr. Little's case on the cheeks.

Dr. GRAHAM LITTLE agreed with Dr. Adamson, who had mentioned his own similar case, shown at this Section, and also at the exhibition of cases at the recent International Congress in London, when the opinions of its nature had been very diverse. In that case circinate vesicating areas, such as were described by Dr. MacCormac, had been the characteristic lesion, and the distribution had been also curiously like that of the present case. Dr. Little deprecated its identification with granuloma annulare, as suggested by one of the members; in the latter disease—of which he had seen a large number of cases—he had never seen or read of vesication as being present at any time. The disease in granuloma annulare was much more deeply situated.

Dr. DOUGLAS HEATH said he saw Dr. Sequeira's case, referred to by Dr. Adamson, several years before it was shown at the Section; at that time

[1] *Brit. Journ. Derm.*, 1912, xxiv, p. 119.
[2] *Ibid.*, 1912, xxiv, p. 270.
[3] *Ibid.*, 1913, xxv, p. 160.
[4] *Ibid.*, 1913, xxv, p. 419.

it was in a more inflammatory state, more like erythema multiforme than when it was shown by Dr. Sequeira. On the knees, elbows, and knuckles the lesions were button-like and of dusky purple colour. This, and the absence of scaliness, suggested erythema multiforme; though, when Dr. Sequeira showed it under the diagnosis "(?) lichen verrucosus" the patches were covered with horny scales. Its type and symmetry were strongly in favour of it being a toxic erythema; and he thought those cases varied a good deal from time to time. In the case he saw, the nurse at the hospital said that at times the lesions were fairly flat, and at others elevated. This present case was somewhat circinate at its margins, just as Dr. Sequeira's case was.

Dr. GRAY expressed his agreement with Dr. Adamson; he had seen one or two similar cases, and the lesions nearly always occurred at the periphery of the limbs and on the knees and the backs of the elbows. There seemed to be different types running into one another. In the case shown by him at this Section the lesions came out very suddenly, and often there was hæmorrhage into them, and some blistering, followed by septic infection. In a case shown by Dr. Bunch at the International Congress, which the speaker regarded as being of the same nature, the lesions were not so acute as in his own. The type which Dr. Sequeira showed seemed to be still more chronic; there was no vesication, and horny thickening was very marked. He had had another case, in a child, in which the lesions were confined, more or less, to the backs of the fingers, which were very thickened and warty, and were associated with very well developed rheumatic nodules about the joints, especially the elbows, knees, and fingers. That case cleared up in an extraordinary manner under ordinary anti-rheumatic treatment. The condition in his other case had slowly disappeared after many recurrences. Dr. Bunch described the case which he showed at the International Congress as granuloma annulare, and he (the speaker) thought there was some connexion between the latter condition and this group of cases under discussion. He also thought that the cases described by Crocker under the name "erythema elevatum diutinum" belonged to the same group. This was true of the cases which had been described by continental observers under that name, but he could not say whether they were the same disease as Crocker originally described.

Dr. MACCORMAC replied that he considered that a superficial necrosis occurred in this case. At one time it had been diagnosed as erythema elevatum diutinum, and at another time it was thought to be granuloma of unknown nature. Dr. Pringle, who had watched the case for some time, had authorised him to say that he had been inclined to the idea that the disease was a multiform senile tuberculide, largely on the ground of the marked central necrosis which occurred; but the microscopical findings definitely excluded that diagnosis, which had been abandoned.

Case shown as Multiple Rodent Ulcer or (?) Epithelioma Adenoides Cysticum.

By E. G. Graham Little, M.D.

Dr. Graham Little showed a male patient, aged 41, with a large number of small tumours on the face, the diagnosis of which lay between "multiple rodent ulcer" and "epithelioma adenoides cysticum," with a leaning, perhaps, to the latter. The case was of very special interest, for it seemed to offer a combination of circumstances which favoured either alternative, and it in fact illustrated the impossibility in our present state of knowledge really to differentiate these two conditions, if, indeed, they were capable of differentiation.

The patient gave the following remarkable family history: His mother had had five or six similar swellings on her forehead which had commenced at the age of 30, and had not ulcerated. No other members of the mother's family had been affected, but her children seemed to show either numerous nævi or tumours, which might be supposed to be of the same type as in the present patient, who was the eldest son. The second son, aged 36, now in Canada, had a tumour, congenital and probably a nævus, as the patient said it was like the tumour present in his own son, which had been seen by the exhibitor, who regarded it as undoubtedly a nævus. This man had no children. The third son, aged 33, had a "nævus" on the forehead, also congenital. He had no children. The fourth son, aged 30, a seaman now with the North Sea Fleet, had a number of tumours "exactly like the present patient's," and situated on the face and forehead. These had made their appearance at the age of 20. He had no children. The patient, A. W., had four children, of whom the eldest, aged 11, had some small tumours which were regarded by his father as of the same character as his own. This boy had been examined by the exhibitor, and was found to have a cavernous nævus about ½ in. in diameter on the chest, which had first shown itself at the age of 7, and a number of dead-white tumours the size of a small pinhead, which were probably ordinary milium, distributed sparsely on the eyelids and about the inner canthus of both eyes. It was interesting that milium had been noted in conjunction with some earlier cases of epithelioma adenoides cysticum.

The patient, A. W., had had no tumours until the age of 20, when

he first noticed the single wart-like lesion now to be seen on his upper lip. In the following twenty years a succession of tumours had made their appearance, chiefly in the neighbourhood of the upper and lower eyelids, and about the inner canthus of both eyes, on the temples, in front of and behind the auditory pinna; and there was a specially thick group of larger tumours at the junction of the forehead and nose. One of the largest tumours was situated on the left side of the forehead, and this was also the most deeply pigmented; it had been excised, and sections were shown which would be described later. There was a single warty and pigmented lesion of the same type on the chest. The appearance of the tumours varied somewhat, some being wart-like; some of a waxy translucence, with either a pink or dead white tint. Some, and especially the larger, had a network of dilated vessels running over the roof of the tumour. A remarkable feature of several of the lesions was the fact that they became pigmented *after* developing at first in the more usual wax-like way. In several cases the pigment was in the the form of a granular deep-black deposit, much as if tattoed with gunpowder. The patient was positive that the pigmentation was secondary to the formation of tumours and not vice versa. Their increase in size was relatively rapid, a swelling as large as a green pea forming within twelve months: the average size was from $\frac{3}{4}$ in. to $\frac{1}{8}$ in., and some sixty discrete lesions in all could be counted, and new ones kept coming. Ulceration had never occurred in any of these.

Histologically, the evidence seemed, if anything, in favour of the diagnosis of rodent ulcer, but the exhibitor did not pretend to be able to distinguish the appearances of epithelioma adenoides cysticum from those of rodent ulcer, and did not think any hard-and-fast grounds of distinction existed. In a paper describing two cases, which were reported as cases of epithelioma adenoides cysticum, contributed to the *British Journal of Dermatology* in May, 1914,[1] the exhibitor had dwelt on the difficulties of establishing any means of differentiation. In a friendly criticism of these cases Dr. Adamson had expressed his opinion that both were examples of rodent ulcer. This present case was an even more difficult and puzzling one to classify. There seemed a certain degree of evidence for family inheritance, although the patient's opinion that his own case and his son's were the same disease had proved illusory, and threw some doubt on his accuracy in the other cases also. If a true observation, it was a factor in favour of making

[1] *Brit. Journ. Derm.*, 1914, xxvi, pp. 173-185.

the diagnosis of epithelioma adenoides cysticum. It was of interest to record the opinion of a general pathologist of rather special knowledge in malignant growths, Dr. Kettle, Assistant Pathologist to St. Mary's Hospital, who had had a long experience at the Cancer Hospital. This observer had seen sections from all three of Dr. Little's cases and his opinion had been that the present case and the second of the two cases reported in May were examples of rodent ulcer and that the first case was epithelioma adenoides cysticum. The development of pigment in the tumours subsequent to their formation was, as far as the exhibitor knew, unrecorded in rodent ulcer, but pigment seemed to have been not infrequently present in recorded cases of epithelioma adenoides cysticum. It was, of course, true that rodent ulcer frequently developed on the site of pigmented moles, and in that way rodent tumours might be pigmented, but the history in this case was totally different, in that the tumours had appeared on non-pigmented areas and had subsequently become pigmented. Pigmentation was therefore in favour of the identification of this case with epithelioma adenoides cysticum, as was also the multiplicity of tumours, their distribution and their early advent, the long period of tumour formation without ulceration, and, above all, the family history, if reliable. But it was interesting to note that the limited and characteristic distribution, and especially the curious straying of lesions, on the chest (which in the continental cases had been the site of election for the appearance of epithelioma adenoides cysticum), the multiplicity, and long immunity from ulceration of the vast majority of lesions, had also been features of the second case recorded in May, which was not entirely accepted as an example of epithelioma adenoides cysticum, under which name it had been described by the exhibitor. It seemed, therefore, rather desirable to revise the whole of our conceptions of the nature of this curious disease and its relation with rodent ulcer.

DISCUSSION.

Dr. ADAMSON quite agreed that this case should be called multiple rodent ulcer. His view[1] was that multiple rodent ulcer and benign cystic epithelioma (of Brooke) were essentially the same disease, but different clinical types; and it was useful to retain the two names as clinical terms. Pathologically and ætiologically they were alike. Both were basal cell epithelioma indistinguishable under the microscope, and both were congenital in the sense of the

[1] *Lancet*, 1908, ii, p. 1133, and 1914, i, p. 810.

Cohnheim embryonic cell-rest theory, and both affected the same areas on the body. The nodules might be described as abortive attempts to form pilo-sebaceous follicles. Embryonic cells destined to become pilo-sebaceous follicles had remained latent until aroused with the general awakening of these structures at puberty (or again later in life when there was a fresh tendency to hair-growth in certain parts); but at this time the dormant cells had lost their power of differentiation and retained only that of proliferation; so that lobulated masses of embryonic cells were formed, but no pilo-sebaceous structure. That the growths of later origin should break down and ulcerate could be readily explained by the lower vitality of their component cells awakened to activity at that period of life; and that would also explain the tendency of rodent ulcer to destroy the normal tissues as its growth advanced; for its cells were decadent cells which would naturally be harmful to the normal tissues among which they were growing. The difference between the benign basal-cell epithelioma and rodent ulcer—which was after all only one of degree, for some rodents exhibited no tendency to invade deeper tissues—was much less wide than the difference between rodent ulcer and true carcinoma. In regard to the distinctions between multiple rodent ulcer and benign cystic epithelioma which the writer had pointed out in 1908, these seemed now to be removed and were no longer an obstacle to the joining up of these two complaints. At a recent meeting of the Section the speaker had brought forward some members of a family of which three females and two males were affected with multiple benign cystic epithelioma,[1] these showing that the disease was not confined to females as was formerly believed. And here was Dr. Little's case of multiple rodent ulcer in a man who gave a family history of several other members of both sexes affected with rodent ulcer or benign tumours, thus demonstrating that multiple rodent ulcer might be a family disease.

Dr. WHITFIELD said he thought there was a more important difference than the mere fact of ulceration between rodent ulcer and benign cystic epithelioma. He believed he could distinguish between the two under the microscope. In the latter condition the growth was strictly limited, whereas in rodent ulcer it was ill defined. Rodent ulcer was not simply a mass of cells which developed at the age of 40 and owing to their degenerate character broke down and ulcerated; it really infiltrated into tissue, including bone, and went straight through it. It was not malignant in the sense of causing widespread metastasis in organs, but it possessed an enormous local malignancy. Even in early rodents one could generally see besides the mass of the tumour outlying branches, and by looking at the edge of the section one got an indication as to which of the two conditions named the case belonged to. Although Dr. Adamson was probably right genetically, in that both occurred as different types of congenital lesion, one of them was essentially a benign

[1] *Proceedings*, 1914, vii, p. 95.

condition and the other was a progressive malignant disease. He did not think the breaking down had anything to do with it; almost any tumour would break down. One did not often see rodent ulcer grow to the size of a hen's egg; but it would grow laterally to any degree, though not producing a greatly elevated tumour. The other kind of tumour was elevated and nearly spherical.

Dr. DORE said that, speaking clinically, he thought there was no doubt that benign epithelioma was potentially a rodent ulcer. He had had two cases under his care in a brother and sister, and in both patients one of the growths had enlarged and assumed the clinical and microscopical characters of a rodent ulcer. He thought the condition was parallel to that of a wart or mole which became malignant later in life.

Mr. MCDONAGH thought that no difficulty need arise about these tumours, if their origin was considered. The epidermis primarily consisted of one layer of cells, and the cells resembled those which constituted later the basal-celled layer. As the embryo developed this one layer gave rise to several other layers, and later still some of these layers developed into special structures, such as hair-follicles, or sebaceous and sweat glands. He considered that a rodent ulcer arose from the most embryonic cells, and was more malignant than the other types, because the cells were more embryonic, but that the malignancy differed entirely from the malignancy of adult tissue. The former was not a true malignancy, but embryonic activity; the latter was true malignancy and due to the nuclei and nucleoli of the host's cells acting as parasites upon the host. If the cells of the tumour arose from cells which were not quite so embryonic, the case would be one of benign cystic epithelioma, to which type the case shown conformed. Tumours still less embryonic would be papillomata, tricho-epitheliomata, sebaceous adenomata, and syringomata, according to the tissue affected. As one could not distinguish microscopically the most embryonic type of cell from one a little less embryonic, therefore one could not diagnose in this way every case of rodent ulcer from every case of benign cystic epithelioma, but clinically they could be easily differentiated.

The CHAIRMAN said that the Section was much indebted to Dr. Graham Little for exhibiting so interesting a case, and inquired what plan of treatment he intended to adopt.

Dr. GRAHAM LITTLE replied that he proposed to keep the man under observation and to withhold any active measures as long as there were no symptoms of discomfort or ulceration.

Two Cases of Arrest of Growth of the Hair of the Scalp of Unexplained Causation.

By E. G. Graham Little, M.D.

Case I.—J. D., a young Welsh girl, aged 20, gave the following history: She had had "eczema" of the scalp at the age of 12, when her hair had been long enough to reach her shoulders. About three years ago she had had an attack of alopecia areata, from which she had apparently speedily recovered in the sense of getting a thick growth of hair, but in the last three years it had remained stationary at the length of about 1 in. The scalp was quite normally covered with hair, which had nothing peculiar about it except its persistent shortness. The pubic and axillary hair was normal. The patient was taken into St. Mary's Hospital with a view of investigating the condition of the ductless glands. A skiagram of the skull showed an apparently normal sella turcica. A skiagram of the chest seemed to show an enlarged thymus, an observation which was in accord with the somewhat undeveloped juvenile type of the patient. Palpation of the abdomen revealed the presence of a mass in the left epigastrium and hypochondrium, not definitely continuous with liver or spleen, and the connexions of which were obscure. It moved with respiration and was apparently deeper than the resonance of the intestine, so that it might be a pancreatic tumour. There was no tenderness on deep palpation of the abdominal wall. Menstruation began at the age of 17 and was normal. Her mental development was rather below the average, but not notably so. Her sugar tolerance had been tested by Dr. Castellain, Medical Registrar to the Hospital, to whom the exhibitor owed the excellent notes. She was able to deal with 8 oz. of sugar without showing it in the urine, so that she might be regarded as showing a somewhat high tolerance in this respect. Individual hairs had been examined microscopically, and there was no evidence of monilethrix or trichorrhexis. The nails were not in any way affected.

Case II.—The second case was a girl, R. A., aged 14, whose hair had never grown longer than its present length of about 1½ in. The mother had brought her to the Skin Department at the East London Hospital for Children when she was aged 3. The hair was then about

the same length as now; no change had been noted in the eleven years intervening. The scalp was rather thinly covered with hair, which was lustreless and lifeless in aspect, but when examined microscopically showed no evidence of moniliform hair or trichorrhexis. Other children of the family were normal as regards the growth of hair. The child's mental development was unusually good, and there were no other symptoms of ill-health. The nails were not altered. She had commenced to menstruate early, three years ago, and after the first year menstruation had been normal. Further investigations would be undertaken in this case when she could be admitted to hospital.

DISCUSSION.

Dr. PERNET asked if the patients showed any thyroid changes?

Dr. GRAHAM LITTLE replied that the thyroid gland seemed to be normal in both cases, and that there was no myxœdematous aspect in the second.

Case of an Infective Granuloma of Unknown Origin.

By DUDLEY CORBETT, M.D.

THE patient was a Belgian youth, aged 23. There was nothing of note in the family history, and he had apparently never suffered from any serious illness. He came to England four years ago, and had worked partly as a waiter and partly in the employment of a butcher. The skin eruption from which he was now suffering appeared for the first time in October, 1910, lasted throughout that winter, but disappeared during the following summer. Since then it had regularly appeared every autumn and cleared up as summer approached. He was admitted to St. Thomas's Hospital on October 27. At first the eruption was taken for a syphilide, and although Wassermann's reaction was negative, he received two doses of neo-salvarsan, together with regular inunctions of mercury. This treatment, if anything, had aggravated the condition.

The eruption itself possessed certain unusual characters. Taking it as a whole, it was papulo-vesicular in type and of widespread distribution, involving the face, neck, trunk and limbs, including the palms and soles. There were no lesions on the scalp and the mucous membranes were spared.

Individually the lesions varied in character, and by watching certain areas of skin it seemed probable that this variation was due to their appearance in different stages of development. The stages occurred apparently in the following order:—

(1) A small papule, yellowish-pink in colour, the size of a pin's head.

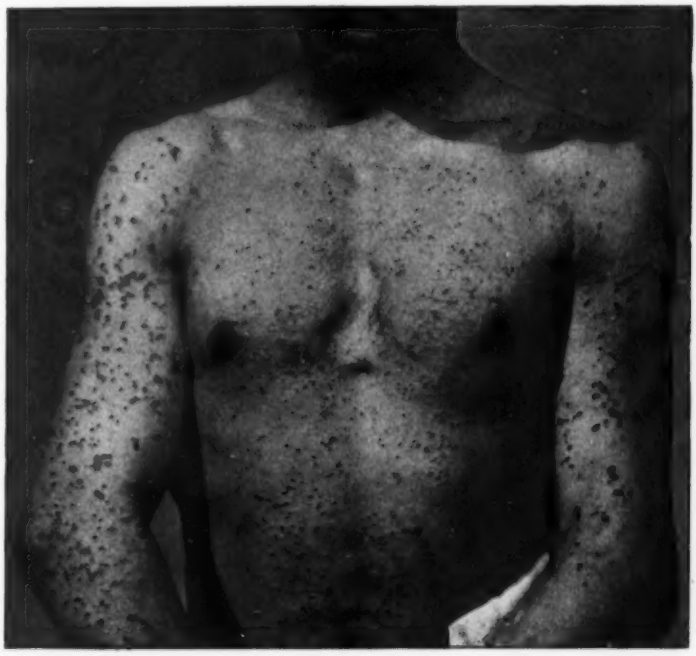


FIG. 1.

An infective granuloma of unknown origin; showing distribution on arms and trunk.

(2) A papulo-vesicle the size of a pea or smaller, pink at the base but whiter and more glistening at the apex. When pierced at this stage a serous fluid could be expressed. The apex was rounded and not depressed.

(3) A flatter papule, bluish-pink in colour, covered with varying degrees of scaliness.

(4) Small and round areas of skin stained faintly purple. This

staining was well shown in a strong light, such as that from an arc lamp.

Except where surface infection had occurred there was no inflammatory areola at the base, and in the finger there was only slight evidence of infiltration of the deeper layers.

He had had on admission a gonorrhœal discharge with some epididymitis, but this had cleared up under suitable treatment. The

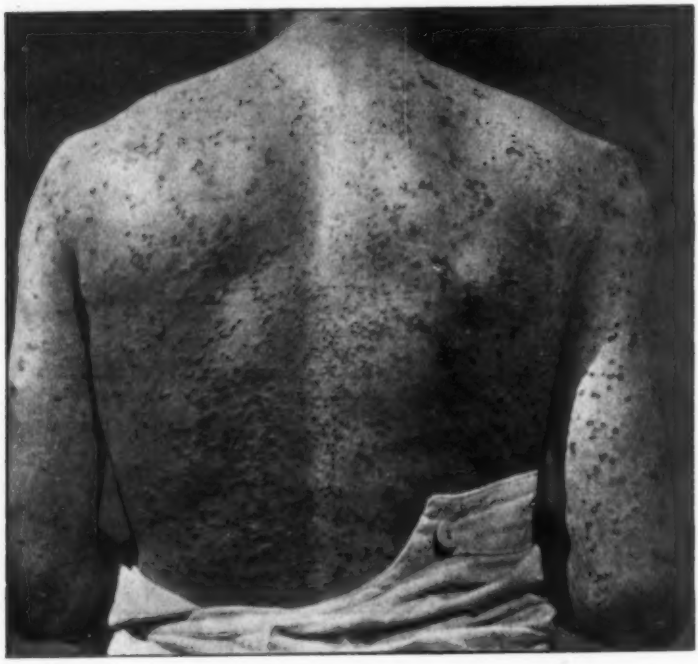


FIG. 2.

Showing distribution on back.

urine was acid and contained neither albumin nor sugar. When antisyphilitic treatment was discontinued he was put on arsenic, and was now taking 10 minims of liquor arsenicalis three times a day. With a view to improving his appearance X-ray treatment had been applied to his face, three one-third pastille doses having been given during the last month. The lesions had yielded rapidly to the X-rays, leaving behind small reddish-stained areas.

Dr. Stainer and he were agreed that the clinical features of this case did not correspond with any previously described condition. Dr. Whitfield then very kindly saw the case and agreed as to its unusual features. He was inclined to think that apart from the history it bore

FIG. 3.

Showing characters of individual lesions.

certain resemblances to an eruptive cystic adenoma, but that diagnosis was impossible without a biopsy.

Sections had been made and Dr. Whitfield had given the exhibitor his opinion upon one of them. It was, however, evident that further investigation was necessary before a diagnosis could be made. For

many reasons it would appear to be an infective granuloma, but the epithelioid character of the cells composing it distinguished it as one of a very unusual type, and at one time led one to think that the new tissue might be epithelial in origin.

DISCUSSION.

Dr. WHITFIELD said that when he first saw the case he realised that to him it was a new disease, not merely an unusual phase of a familiar disease; and under the microscope its features were unfamiliar to him. He was not prepared to support very strongly his idea that these were epithelial cells, because he saw that there might be a fallacy. But he was not familiar with a granuloma which behaved in the same way. So that either he had to admit that these were epithelial lobes such as he had never seen before, or that they were arrangements in endothelial tissue in a granuloma which he had not seen hitherto. In some places one saw an extraordinary regularity in the intercellular connexions, while in other places it was very difficult to distinguish between the surface of the tumour and the true overlying epidermic tissue. The pathology seemed to reveal a new and undescribed disease.

Dr. ADAMSON said he thought the condition was a xanthoma diabeticorum; it was more like that, histologically and clinically, than anything else. It would be interesting to know whether the patient was a beer-drinker. Several cases of xanthoma had been recorded in beer-drinkers who had no glycosuria.

Dr. GRAHAM LITTLE said he was glad to hear Dr. Adamson's opinion, because before seeing the section that had been his own suggestion. He had seen xanthoma tumours as red as in this case; yellowness was not absolutely essential to the diagnosis of xanthoma.

Dr. PERNET elicited from the patient that he had only discontinued beer-drinking since the rash appeared. He agreed that some of the xanthoma rashes were not xanthomatous in colour. There was some points about the case in favour of its being xanthoma, though there was no sugar in the urine. Perhaps, too, the eruption had been modified by the various treatments employed. In some areas the individual lesions were extremely like lichen planus, a condition which manifested clinical variations.

Mr. MCDONAGH said he regarded the case as one of infective granuloma. The lesions left scars, which was against the diagnosis of xanthoma diabeticorum, and the lesions on the penis reminded him of lichen nitidus. From an examination of the histological specimens he thought that the cells which had given rise to so much discussion were endothelial cells, and that the specimens resembled the endothelial type of tubercle. One of the sections resembled very closely the histology of lichen nitidus, and therefore he thought that the disease was probably tubercular, and that a protozoal or fungous cause would have to be excluded.

The CHAIRMAN drew attention to the remarkable configuration of the lesions. In view of its rarity and special interest he invited the exhibitor to submit it to the standing Pathological Committee for further investigation and report.

Dr. CORBETT replied that he was very willing to submit it to the Pathological Committee, but he wished first of all to make further sections and to stain some for Altmann's granules.

Case for Diagnosis; (?) Xantho-erythrodermia Perstans.

By S. E. DORE, M.D.

THE patient was a man, aged 35, who presented an acute erythematous macular eruption on the trunk of ten days' duration, with many of the characters of pityriasis rosea but with a peculiar yellow tint. On the front of each shin there was also a smooth rectangular patch of chronic dermatitis of a deep yellow colour which had been present for a year, and on the scalp there were several patches of alopecia areata of about the same duration. In view of the fact that the eruption on the trunk was similar in colour to that of the patches on the shins it was thought that the two conditions might be part of the same disease and a tentative diagnosis of xantho-erythrodermia perstans was made.

DISCUSSION.

Dr. PERNET did not consider that the rash on the body in this case corresponded to the diagnosis of xantho-erythrodermia perstans. The duration of the condition was against it. He referred to a case of xantho-erythrodermia perstans in a young adult he had brought before the Section.[1]

Dr. GRAHAM LITTLE did not think the colour was against the diagnosis of pityriasis rosea; a number of cases of the disease had an even darker tint. He had shown a case in which the lesions were almost walnut colour and gradations from that shade to pink and yellow were reported. He regarded the lesions on the abdomen as pityriasis rosea, and as having no connexion with those on the leg and head.

The CHAIRMAN remarked that his opinion coincided with that expressed by Dr. Little. He did not think complete reliance could be placed on shades of colour in order to establish the diagnosis of pityriasis rosea. It was particularly difficult to estimate them by artificial light.

[1] *Proceedings*, 1912, v, p. 106.

Case of Alopecia Areata of the Scalp and Left Eyelids in a Boy, aged 11.

By S. E. Dore, M.D.

Both eyelids on the left side were completely devoid of hair and there were several patches of alopecia of the scalp. The right eyelids and eyebrow and the left eyebrow were unaffected. The boy had had a similar attack affecting the scalp and left eye only, about a year ago. Recovery ensued, but the hair had fallen again from the same parts during the past two months. Dr. Whitfield had published a small series of cases of alopecia areata of the scalp associated with some error of refraction, but in the present case the vision had been carefully tested and was found to be normal.

DISCUSSION.

The Chairman asked whether Dr. Dore had seen any case in which complete loss of eye-lashes followed the presence of pediculi apart from treatment. He had seen an instance of this in a young child. The pediculi were carefully removed after the use of a mild antiseptic fomentation to soften the crusts. Subsequently, the lashes were completely shed on both sides of the face. There was no alopecia elsewhere. Loss of eye-lashes on one side associated with alopecia was very rarely met with.

Mr. Samuel asked if there was any history of local trauma to the affected parts.

Dr. Dore replied that he had not seen alopecia of the eye-lashes following pediculosis; but he had pointed out that pediculosis of the scalp not uncommonly preceded alopecia areata, even in adults. There was no history of trauma.

Case of Lichen Planus Hypertrophicus, with Excoriations, in a Woman, aged 56.

By S. E. Dore, M.D.

The eruption began six years ago, but had been worse during the past three years. It was chiefly situated on the hips and thighs, with scattered lesions on the back, shoulders and arms, and consisted of raised violaceous plaques, irregular in shape and size,

many of which were deeply excoriated on the surface. Some of the patches had disappeared, leaving atrophic scars. The mucous membrane of the mouth was not affected. The patient complained of constant itching. She had had her ovaries removed fifteen years ago and it was possible that there might be an additional neurotic element in the case. The exhibitor thought that excoriations were rare in this disease and that spontaneous disappearance of the lesions was uncommon.

DISCUSSION.

Dr. GRAHAM LITTLE asked whether the excoriations preceded the thickening. Was it lichenification of traumatic lesions? Could artefact causation, for example, be entirely excluded.

The CHAIRMAN confirmed the diagnosis expressed by the exhibitor and regarded the case as one in which the hypertrophied masses were secondary to the papules of lichen planus, the special characteristics of which were so well known. In his experience the itching was always much less severe in the hypertrophic stage than in an ordinary development of lichen planus. He had seen instances in which these masses had disappeared spontaneously, leaving macules corresponding in character with those now seen on the patient's body, which at first sight suggested superficial scarring but which eventually cleared away. He considered that the habit of scratching was calculated to keep up the tendency to papule formation and certainly to add to the secondary hypertrophy when it existed. Prolonged baths and X-ray treatment were likely to be of much benefit to the patient.

Dr. DOUGLAS HEATH said he did not concur in the diagnosis of lichen planus. If it were lichen planus he thought one should find the original lichen planus papule or patch. He suggested it might be a severe prurigo, and that the severe itching caused the patient to tear herself. Most of the lesions seemed to have been aggravated by interference on her part.

Dr. GRAY said the Kromayer lamp had a good effect on these extensive cases, starting with five-minute exposures at 25 cm. distance, once a week or so, the dosage depending on the amount of reaction. Many of these conditions cleared up when the itching was stopped.

Dr. ADAMSON said he had always found hypertrophic lichen planus was very difficult to cure. In his experience X-rays had no curative effect on the disease.

Dr. MACCORMAC said that after lumbar puncture some cases cleared up marvellously; even in twenty-four hours they might begin to do so.

It certainly seemed to relieve the itching; and a good many of the lesions of lichen planus were the result of scratching. He had employed lumbar puncture successfully in various pruriginous conditions.

Dr. DORE, in reply, said he had not been able to make out definite lichen planus papules in the case. The hypertrophic variety of lichen planus did not usually yield readily to X-rays, but he had treated two or three cases with success.

Case of Lupus Erythematosus of the Fingers, with Lupus Pernio on the Nose.

By P. S. ABRAHAM, M.D.

THE patient was a female, aged 50, who had never been very strong, married, with two children, the youngest, aged 17, being healthy. She had had a miscarriage nine years ago. There was a history of abscess in the ear thirty years ago, and of abscess in the neck seventeen years ago. No history of tubercle in the family. The exceptionally extensive lesions on the hands and fingers first appeared on one knuckle in September, 1913, and on the ears and nose last March. The affection on the hands and fingers gave rise to much irritation at all times, and there was also irritation in the toes where she used to have chilblains. The patient's pulse was rapid and her circulation feeble. The lesions on the hands and fingers had some resemblance to hypertrophic lichen planus, but the typical condition in the ears was sufficient to confirm the diagnosis of "lupus erythematosus."

DISCUSSION.

Dr. DORE said he agreed with Dr. Abraham's diagnosis although the patches on the hands simulated lichen planus. He thought, however, that the patch on the nose was also characteristic lupus erythematosus and not lupus pernio.

The CHAIRMAN entirely agreed with the observations of Dr. Dore, who exhibited this patient for Dr. Abraham.

Mr. H. C. SAMUEL said the case was more like the scaly type of erythematous lupus generally seen on the scalp than that usually met with on the hands.

Dermatological Section.

January 21, 1915.

Dr. J. J. PRINGLE, President of the Section, in the Chair.

Pathological Committee's Report on Dr. Sibley's Case.

THE HON. SECRETARY (Dr. Dore) read an abstract of this Report, and the President intimated that the full report was available for any member who wished to peruse it.

Report of Pathological Committee on the Cases presented by Dr. Sibley and Dr. Sequeira.

DR. SIBLEY'S CASE OF LYMPHADENOMA WITH GLANDULAR AND CUTANEOUS LESIONS.[1]

A MEETING was held on October 2, 1914, Dr. James Galloway in the chair. Dr. Sibley's patient was present and was examined.

The account of the patient's case as published in the *Proceedings* was read, and microscopical preparations showing the skin tumours in his case were examined. It was felt to be desirable to obtain further information respecting this case, and Dr. Sibley arranged that one of the lymphatic glands in the axilla should be excised for microscopical examination, and that a further examination of the patient's blood should be made. Dr. Whitfield and Mr. McDonagh were asked to examine the microscopic specimens of the skin already prepared and the new material to be obtained from Dr. Sibley, and to report in due course to the Committee.

A second meeting was held on December 3, and careful reports were read by Dr. Whitfield and Mr. McDonagh on the microscopic material submitted to them for examination.

[1] Exhibited at meeting of July 16, 1914 (*Proceedings*, 1914, vii, pp. 276-281); and again at meeting of October 15 (*Proceedings*, 1914-15, viii, p. 2).

Dr. Whitfield's report discussed critically the microscopic appearances, and was based chiefly upon the structure of the lymphatic gland which had been excised, and from which microscopic preparations had been made by Mr. McDonagh. The conclusion of his report is to the effect that the whole picture strongly resembles that of the lymphatic gland in lymphadenoma, as described and figured by Dr. Andrewes. The presence or absence of eosinophile cells in the infiltration could not be decided, as the material had not been stained for the purpose of demonstrating these structures. Dr. Whitfield concluded that the case of disease under discussion was one of lymphadenoma with miliary growths in the skin.

Mr. McDonagh's report also discussed critically the histological appearances, both of the skin and especially of the lymphatic gland which had been examined. He compared the sections of both the skin and the lymphatic gland with fig. 11 of his recent paper in the *British Journal of Dermatology* on "The Rôle played by the Lymphocyte." He concluded that "the endothelial cell is the cell attacked; consequently there is a great multiplication of them, and, owing to their great tendency to increase as shown by being multinucleated, they are unable to generate lymphocytes. The few lymphocytes formed will also be degenerated; hence they fail in their characteristic lipoid-globulin envelope, and consist of irregular masses of nuclein." Mr. McDonagh concluded, from the histological appearances, that the condition was one of leukæmic cutaneous lymphocytoma of the endothelial cell type, and that the prognosis of the case would be bad.

The report of the blood examination supplied by Dr. Sibley was then discussed. As it was considered advisable that an independent examination of the blood should be made, Dr. Galloway arranged that the patient should be sent to Charing Cross Hospital and that the blood should be examined by Dr. Topley, Clinical Pathologist to Charing Cross Hospital. Dr. Topley's report is now submitted :—

"December 31, 1914 : Red blood cells, 4,700,000 per c.mm. ; hæmoglobin, 62 per cent. ; colour index, 0·66 ; leucocytes, 28,140 per c.mm. ; polymorphonuclears, 35·2 per cent. ; small lymphocytes, 15·4 per cent. ; large lymphocytes, 6·0 per cent. ; large hyalines, 3·6 per cent. ; eosinophiles, 39·6 per cent. ; basophiles, 0·2 per cent. The stained red cells show nothing abnormal."

Dr. Galloway's comment on the new blood count is as follows : There is distinct leucocytosis, but not sufficient in amount to make the diagnosis of leukæmia, nor is the character of the leucocytes suggestive of this

disease. The blood, however, shows a very remarkable number of eosinophile (oxyphile) leucocytes. The blood slides show a remarkable picture of eosinophilia. The basophiles (mast cells) are almost absent. The eosinophilia may very well be associated with the marked chronic inflammatory skin change present in this patient, and may fall into the same category as the eosinophilia present in other forms of chronic dermatitis, such as in certain pemphigoid conditions. There is clearly a marked leucocytosis, but it is possible that the chronic dermatitis may be sufficient to produce this condition.

After a further discussion at a meeting held on January 11 the following statement of the conclusions arrived at by the Committee was agreed upon: The evidence submitted, both from the clinical and from the histological points of view, seems to be in favour of the diagnosis of lymphadenoma with glandular and cutaneous lesions. It is agreed that the diagnosis of lymphadenoma must be made with the full recognition of the obscure origin of this affection and also of the insidious nature of the onset of leukæmia of the "lymphatic" type.

Dr. Sequeira's patient died soon after the Committee was appointed, and the problems presented by his case are at present being investigated in the pathological laboratory of the London Hospital. The Committee, therefore, is unable at present to fulfil the instructions given by the Dermatological Section, Royal Society of Medicine.

Dr. Whitfield's and Mr. McDonagh's reports are appended.

Report on Dr. Sibley's Case, by Arthur Whitfield, M.D.

(*I*) *The Skin.*

(*a*) *Epithelium.*—This is merely stretched out and somewhat thinned over the new tissue below. The papillæ are diminished in height or completely flattened out over the centre of the infiltration, while they are elongated and narrowed at the edges. These are the alterations that are usually associated with new tissue formation deep in the corium, as contrasted with that beginning in the papillary layer (e.g., in mycosis fungoides), in which the undulating line caused by the alternating ridges and papillæ is exaggerated over the centre of the infiltration.

(*b*) *The Corium.*—The corium is the seat of a massive but somewhat diffuse infiltration. The main seats of this are the middle and lower parts of the corium, and it would appear that the papillary body is only secondarily invaded, as the appearance of the infiltration in the papillary body closely resembles that of the middle of the corium at the lateral

edges of the infiltration. The fibrous tissue in the centre of the infiltration is finely reticulated, but whether this is due to newly formed fibrous tissue or to the mere rarefaction of the old it is difficult to say. On the whole, from the arrangement of the fibroblasts and that of the centre of the infiltration I am of opinion that at any rate some of it is newly formed.

None of the sections was stained to demonstrate the elastic tissue; the whole of the infiltrated area, especially towards the periphery, is strikingly œdematous and very widely dilated vessels are numerous. It is again difficult to state definitely whether these are blood-vessels or lymphatics, as they have lost their contents, but from a study of their walls and the tissue immediately surrounding them I believe them to be lymphatics. All the vessels are surrounded by a wide zone of well-formed cells which belong to the ordinary "clasping" type. The main infiltration varies greatly in different sections. I believe this to be due to the fact that the growth has a centre, or rather several centres and a thick surrounding zone. In most of Dr. Sibley's sections the knife (if I am right) has passed through the outer zone in a tangential direction, giving a picture of only a diffuse, rather dense lymphoid infiltration. In one of Mr. McDonagh's sections the knife has evidently passed more nearly through the centre of the infiltration, giving a different and more informing picture. Taking the latter as giving a more accurate representation of the whole anatomy of the formation, one finds the following: In the centre the growth has a tendency to form follicles, but these are not developed very completely. At all events the infiltration is grouped into ovoid masses with the reticular tissue arranged in concentric layers. The cells in the centre of these rudimentary follicles are large and their staining less intense than that of the cells outside.

The cells of the infiltration consist of:—

(1) Large, pale-staining endothelioid cells, usually with one but occasionally with more than one nucleus; the nucleus is vesicular and poor in chromatin, the nucleolus is obvious but is stained bluish instead of red as is usually the case. This I believe to be due to lack of differentiation in the staining, since it is a very rare abnormality, and I notice that the same accident has happened in many instances in the nucleoli of the epithelium, which appears to be otherwise normal. There is a fair number of multinucleated large cells present, such as one commonly finds in granulation tissue, that is, they are more or less oblong cells with processes running off into the surrounding tissue. The nuclei are grouped into a clump in the centre and not in rings or horseshoes as

in the tubercular and foreign body giant cells. I take these to be syncytia formed of the previously described endothelioid cells.

(2) Young fibroblasts, long in shape, evidently active, and apparently forming fresh reticular tissue.

(3) Cells with indeterminate nuclei and spongy protoplasm stained a bright cherry-red. These are what are usually described as "lymphoblasts" when met with in lymphatic glands, and they are more or less closely related to plasma cells.

(4) Small lymphoid cells with deeply staining nucleus and little or no protoplasm.

(5) Mast cells.

Cells 1, 2, 4, are numerous, cell 3 is scanty, cell 5 rather abundant. I saw no plasma cells, unless one is inclined to class cell 3 under this heading, which I am not. Mitosis is apparently normal in type and fairly abundant; it gives the impression that the growth is firmly developed. Unless one can apply the term "degeneration" to the cells which show a pale staining in the centre of the growth, there is none evident. Personally, I think it would be erroneous to consider these pale-stained areas degenerate; I regard it rather as a sign of activity, since it exactly resembles what one sees in the centre of the lymph follicles of the normal lymphatic gland.

(*II*) *The Gland.*

It is unfortunate that the sections do not take in the periphery of the gland and the capsule. One is therefore unable to state whether there is any transgression of the capsule, and further, it is more difficult to study the broad anatomy. However, the structure seen is remarkable, and the tissue is scarcely recognisable as true lymphatic gland. There is a total disappearance of all the follicles, a marked diminution in the numbers of the lymphocytes, and a marked increase of the large endothelial cells. The sections were not stained to demonstrate either the reticulum or the presence or absence of eosinophile cells. The reticulum I should say was increased in amount.

The whole picture strongly resembles that of the lymphatic gland in lymphadenoma as described and figured by Dr. Andrewes,[1] minus, of course, the eosinophile cells which may or may not be present. I should say, therefore, that the disease is lymphadenoma with miliary growths in the skin.

[1] Bowlby and Andrewes, "Surgical Pathology and Morbid Anatomy," 6th ed., 1913, p. 268.

Histology of Dr. Knowsley Sibley's Case, by J. E. R. McDonagh, F.R.C.S.

Epithelium.—The epithelium is only secondarily affected, in that it is flattened out, and its layers reduced, over that part of the corium in which the main mass of the cellular infiltration is situated. The cellular infiltration reaches up as far as the basal layer of the epidermis, and there is not that space between the two which is said to be characteristic of leukæmia cutis.

Corium.—Although there are main masses of cellular infiltration, which are more or less circumscribed and do not invade the subcutaneous tissue, the whole of the corium is studded with a cellular infiltration to a greater or to a less degree. In the periphery of the main masses, what at once strikes the eye is the marked dilatation of the capillaries and lymphatics, the perivascular arrangement of the infiltration, and the great number of mast cells. In some sections there are numerous eosinophile cells. If the vessels and lymphatics are more closely studied one notices that there is a marked endothelial proliferation, which in some places is sufficient to block the lumen. Some of the endothelial cells have extended peripherally where the main increase of cells are connective tissue cells and lymphocytes. There are no plasma cells. The main masses are less cellular owing to the fact that several of the cells have degenerated, and that the cell playing the most part in the infiltration is the large, badly staining endothelial cell. In the main masses there are not many lymphocytes, and no plasma cells or mast cells, but here and there, where a few endothelial cells have coalesced, typical giant cells are to be seen. In the immediate periphery the number of lymphocytes are increased; there are a few mast cells, no plasma cells, but a very marked increase of connective tissue cells. Especially noticeable about the cellular infiltration, as a whole, is the poor affinity the endothelial cells and lymphocytes show for pyronin and methyl green, especially for the former. This means not only that the protoplasm of the cells is very poor in lipoid-globulin and therefore markedly degenerate, but that the nucleic acid content is diminished, which renders the cell more degenerate still.

Examining the cells individually, the following characters are to be noticed:—

Endothelial Cells.—The protoplasm is swollen, stains faintly, and is sometimes granular. In a few of the cells embryo lymphocytes are

to be found, but they are very few in number and not pyroninophile. On the other hand, they show a great affinity for methyl green, with which they stain very deeply. Instead of the embryo lymphocytes being well formed, their nuclei are more often to be seen broken up, so that the protoplasm of the endothelial cell appears to be crowded with small masses, which stain almost black with methyl green. The nuclei of the endothelial cells are swollen; many cells have one or more nuclei, and the nuclei may contain one or more nucleoli. The nucleoli are remarkable in being so faintly pyroninophile.

Lymphocytes.—Those already formed stain faintly with methyl green and are degenerated. Here and there is to be seen a feeble attempt to form plasma cells, the protoplasm of which is irregular and only stains faintly with pyronin. A few embryo lymphocytes are to be found, but it is an exception for them to contain a lipoid-globulin and pyroninophile protoplasm. Most of the embryo leucocytes are merely masses of nuclein.

Lymphatic Gland from Axilla.—The gland is a very small one, but practically the whole of its structure is altered. There is very little cortex, as most of the gland consists of abnormal follicular tissue. The number of lymphocytes are diminished, while the endothelial cells are very much increased. In the gland section there are a few plasma cells and more normal embryo lymphocytes. The endothelial cells resemble those already described in the skin section.

The sections of both the skin and the lymphatic gland resemble fig. 11 of my recent paper in the *British Journal of Dermatology* on the rôle played by a lymphocyte, &c., but with certain differences.

The endothelial cell is the cell attacked; consequently, there is a great multiplication of them, and owing to their great tendency to increase, as shown by being multinucleated, they are unable to generate lymphocytes. The few lymphocytes formed will also be degenerated; hence they fail to exhibit their characteristic lipoid-globulin envelope, and consist of irregular masses of nuclein.

From the histological appearances I should imagine that the prognosis of the disease would be bad. In my opinion the condition is one of aleukæmic cutaneous lymphocytoma of the endothelial cell type.

The PRESIDENT (Dr. J. J. Pringle) said he wished, in the name of the Section, to thank the whole of the Pathological Committee for the extreme care with which they had investigated this very difficult case; and especially Dr. Whitfield and Mr. McDonagh for their exceedingly valuable and elaborate reports upon it, which must have involved very much labour on their part.

Dr. KNOWSLEY SIBLEY desired to endorse cordially the President's appreciative remarks concerning the labours of the Committee on his case. Their elaborate report was of great interest not only to himself but to every member of the Section, and he was very grateful for the trouble they had taken.

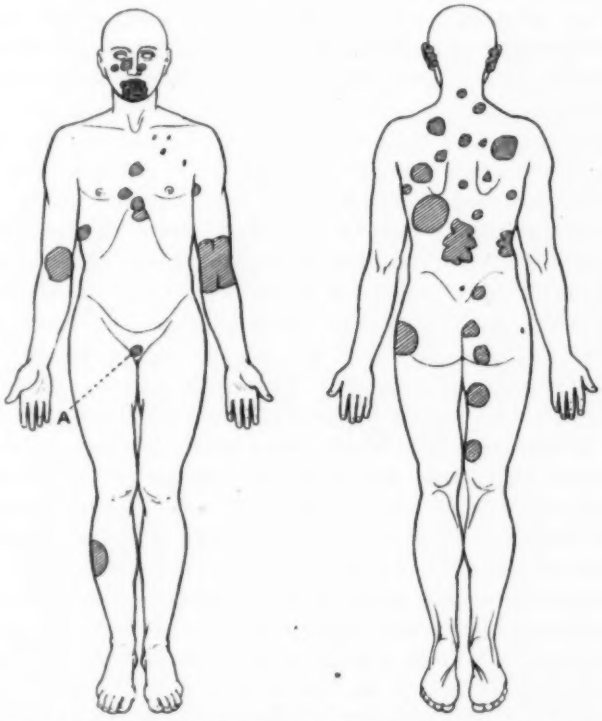
Case of Pemphigus Vegetans.

By J. J. PRINGLE, M.B.

THE patient, a man, aged 28, was a private in the Territorial Army. He previously had been employed as a labourer in dye-works. He was first seen by the exhibitor on November 26, 1914, in one of the London Military Hospitals, and the gravity of his condition being recognised, he was removed the following day to the Middlesex Hospital. The disease for which he was shown apparently began in the end of September, when his skin was said to have been chafed by his "identity disk" over the left side of the upper part of the chest and in the left armpit. Large blisters had formed there and had subsequently appeared with great rapidity over other parts of his body. The history as to the date of development of the lesions in the mouth was vague, but there could be no doubt that they appeared very early in the course of the disease, as they were striking elements in the case when he was first seen. The distribution of the disease at that time is indicated in the accompanying exceedingly rough schema.

The initial lesions were all bullæ, varying in size from a pea to a hen's egg, or large excoriated and discharging surfaces obviously resulting from the rupture of bullæ. The bullæ and excoriations were present in greatest abundance in the axillæ and bends of the elbows, over the lower part of the face, behind the ears and over the back, and particularly large blebs were present over both buttocks. These arose abruptly from healthy skin and there was no trace of herpetiform grouping anywhere. The distribution presented no marked symmetry, except in the armpits and bends of the elbows, and there was a conspicuous absence of blebs in the inguinal regions. The contents of all the bullæ were purulent. There were three large blebs on the right thigh and leg, but the left thigh and leg were absolutely free from disease and had remained so throughout. There was one large bleb on the very long prepuce and marked erosion of its mucous lining and of the glans penis. The lips and inside of the mouth were very con-

spicuously involved, blebs and deep erosions being present over both the hard and soft palates and on the tongue and buccal mucous membrane, and some were observed even in the nostrils and on the conjunctivæ. The breath was horribly fœtid. Owing to pain the patient articulated and swallowed with extreme difficulty, so that he could only be fed with liquids.



Schema showing the distribution of the disease. **A**, large bleb on penis; much discharge from inside prepuce.

When first observed, the contents of all the bullæ were purulent, and throughout the case the early invasion of the essential lesions by staphylococci—certainly within three hours after their appearance—had been very striking, and probably accounted for the markedly septic temperature. On December 8, however, for the first time a few small, quite fresh blebs with clear contents had been discovered on the front of the chest, serum cultures from which were absolutely sterile. The

Wassermann reaction had been frankly negative throughout, and no growth had occurred in blood cultures after six days at 37° C. Agar cultures from the excoriations had yielded staphylococci, a diphtheroid bacillus and abundant *Bacillus proteus*. The blood picture had been practically normal throughout, and it was especially to be observed that there had been no eosinophilia. The examination of the urine was also negative, giving no evidence of acidosis or of intestinal toxæmia. It contained no albumin or sugar or aceto-acetic acid, and no abnormal amount of indican or of phenols. There was no bacilluria. The bowels had been fairly regular throughout, but the motions were intensely fœtid.

The patient remained extremely ill till Christmas, his condition having been aggravated by a sharp attack of influenza; but since the New Year a remarkable improvement both in the local and general condition had occurred, which permitted of his being brought from the hospital and exhibited. Only a few abortive vesicles had developed during the preceding three weeks, and the huge erosions formerly present over his back, neck and chest had healed up, although the epidermis which had formed over them was extremely delicate, and separated off with great facility if any portion of the dressing adhered, generally to reform again rapidly. There was no trace of scarring at any point. He had gained nearly a stone in weight, and his general condition had improved out of all recognition. His temperature, however, was still abnormally high and maintained the same septic type, and to the same degree, as during the earlier stages of his illness. Ever since the subsidence of the bullæ in the axillæ the skin of these regions had presented a pronounced condition of vegetative dermatitis—or condylomatosis—which justified the connotation of the case as one of pemphigus "vegetans"; and the early and severe implication of mucous membranes accorded with general experience of the type of disease thus designated. Although the progress of the case under treatment had hitherto been exceptionally favourable, it must not be forgotten that a few cases of recovery, or at all events of marked temporary amelioration, had been reported by competent observers; and the patient's comparative temporary *bien-être* might merely be an intermission in the course of a tragically lethal disease.

Finally, the exhibitor desired to draw especial attention to the treatment he had adopted. Since December 17 the case had been treated by weekly injections of a mixed vaccine (prepared by Dr. Carl Browning) of *Staphylococcus albus* from his blebs, of his *Bacillus proteus*, and of four coliform bacilli isolated from his fæces. At the same time he had had

prolonged starch-cyllin-boric antiseptic baths, followed by the swabbing of all the parts chiefly affected with peroxide of hydrogen lotion, and the free application of a thin zinc-ichthyol cream. It is worthy of note that his improvement had been coincident also with the nightly administration of 5 gr. of the compound soap pill, a remedy which was recommended by Sir Jonathan Hutchinson, Dr. Liveing, and many of the older British dermatologists in similar cases. The relative amount of credit to be apportioned to these measures could not be accurately gauged, but much of the patient's comfort and well-being was, doubtless, directly attributable to the assiduity with which he had been nursed.

DISCUSSION.

Dr. G. PERNET agreed with the President's diagnosis, although the case differed in the great improvement which had occurred, from those he had seen —his own and the late Radcliffe-Crocker's—all of which died. One case was treated with vaccines, but death occurred in a few months. He asked if Dr. Pringle attributed the improvement in this case to the vaccines—i.e., if up to the time of starting the vaccines the patient was not doing well as the result of general antiseptic treatment and good nursing. In a fatal case of which he published full particulars in Boeck's "Festschrift,"[1] vaccines seemed to help at first, but the ultimate results were *nil*. The prognosis of pemphigus vegetans he regarded as always gloomy. It was unusual for one limb to escape the disease, as was the case with the left leg in this patient, and it would be interesting to know whether he had had an injury to that leg. A nerve injury might modify the amount of eruption.

Dr. WHITFIELD said there appeared to be two types of pemphigus vegetans, varying in their degrees of severity. He had at present the first case of typical pemphigus vegetans which had ever been under his care, although he had seen some instances in consultation, and exhibited at societies. His case was almost entirely a mass of vegetation; indeed, bullous lesions were very scanty. About May last there were severe bullous erosions at the back of the mouth. The diagnosis of pyorrhœa had been made, and the back teeth had been removed, but instead of improving matters it aggravated them. Two or three months later the man was attacked with what his doctor called "pruritus ani," but there were no bullæ on the body. The whole perineal and sacro-inguinal region formed, however, a mass of peculiar bluish-grey condylomatous-looking material. He admitted the patient to hospital as soon as possible, and he had developed one group of clear vesicles on his thigh, from

[1] Pernet, "A Case of Pemphigus Vegetans treated on general lines and by means of Vaccines," *Arch. f. Derm. u. Syph.*, 1911, cx, pp. 509-526.

which cultivations had been made. There had been some lesions in the left eye, and very severe bullous lesions inside the nose. The vegetative lesions, however, were not simply overgrown tissue. He found in portions removed by biopsy that there were bullæ even at the base of these vegetations. Cultivation of the only group of bullæ showed merely staphylococci and streptococci. Two cultivations of the blood and of the urine, and the Wassermann test, were all negative, and the cerebrospinal fluid was normal. He had, therefore, come to the end of his resources as to the cause. In reply to Dr. Pernet, Dr. Whitfield said the withdrawal of cerebrospinal fluid for examination made no difference to the patient; he had been carefully watched for any effects of the procedure.

Dr. SEQUEIRA agreed that there could be two types of this disease. He had had under his care a case of the mild type, in which the lesions began as blebs. The patient was sent to him by Dr. Corner, of Mile End, and she had a large number of vegetations in the flexures, as well as bullæ. He took a gloomy view of her case. She was placed in the septic ward, and given large doses of arsenic, and antiseptic dressings were applied. Recovery ensued, and the patient passed out of his care. Her stay in hospital extended over several months. Cases had been recorded in which the lesions seemed to be more related to dermatitis herpetiformis than to those of true pemphigus.

Dr. MACLEOD agreed with Dr. Whitfield's remark that possibly there was a mild and a severe type of pemphigus vegetans. The point that struck him most about the condition was the fact that in nearly every investigation of the early vesicles which had been made the contents had been found to be sterile, though they rapidly became contaminated with ordinary skin cocci. He considered that the vegetations were probably the result of secondary staphylococcic infection.

Dr. GRAY said he had had a case which might possibly belong to this group, that of a girl, who was in a surgical ward at University College Hospital with a psoas abscess. She had been in for about a year, with an open sinus. She also suffered from psoriasis, and had been under arsenic for five or six months in hospital. One day she developed some bullæ on the front of both wrists, and a few days later in both axillæ and then in both groins. They increased in size, then burst, leaving large fungating areas, which discharged freely. Some small bullæ also appeared in one or two of the psoriasis patches; otherwise they were limited to the regions named. The arsenic was discontinued, as he thought it might have been responsible for the lesions, which were then treated antiseptically. The condition cleared up in about a month. So far as he knew, she had no recurrence. He did not know how to classify the disease.

The PRESIDENT (in reply) said that cases of pemphigus vegetans undoubtedly varied widely in their degrees of severity. Cases of comparatively mild type

certainly occurred, and probably the reported cases of recovery were authenticated by fact. The four cases which had been under his care previous to the present one had all died in from six to eight months. In one of them, a young man (whom Dr. Whitfield would remember), the bullæ were confined to the throat and mouth for fully three months before they appeared on the lips and face. In answer to a question by Dr. Parkes Weber, he said that arsenic had been given in full doses when the patient first came under treatment, but it was discontinued as it seemed to cause diarrhœa, and the vaccine treatment was then substituted. He shared Dr. MacLeod's view that the vegetations were the result of secondary staphylococcic infection. There was no history or evidence of nerve injury to the left leg and thigh which would account for its immunity from eruption. Finally, he repeated his statement that he was unable to commit himself to any definite opinion as to the relative value of the vaccine, as compared with the other methods of treatment employed, and his impression was that the temporary improvement, which was manifest, was probably illusory.

Case of Lupus Erythematosus.

By George Pernet, M.D.

The patient was a man, aged 53, in whom the disease had commenced six months previously in front of the left ear. Three months later the end of the nose became involved. In front of the left ear there was a semicircular lesion with its convexity directed towards the cheek, and it consisted of a well-defined narrow border, within which there was superficial atrophy. The ear itself was also affected. There was no similar symmetrical lesion on the right side, but the right ear showed signs of slight involvement. The end of the nose was reddened, with markedly accentuated sebaceous plugs, and when the patient was first seen the tip of the nose was occupied by a soft, moist crusting, which when removed showed gaping sebaceous orifices beneath. The patient was otherwise healthy, and it was not possible to discover any source of toxic trouble. There had been some history of exposure lately as the patient had been riding on the tops of omnibuses. There was no history of phthisis in the family. The case was shown on account of the age, which was rather later than usual, and the asymmetry. He had improved on salicin internally, and a calamine lotion locally.

Case of Pityriasis Rubra Pilaris associated with Pregnancy.

By H. W. Barber, M.D.

The patient's age was 43. At the time of demonstration she was seven months pregnant, this being her seventh pregnancy. She had never previously had any skin trouble. There was no evidence of tuberculosis in the family, nor did she present any symptoms of such infection herself: a von Pirquet reaction had not yet been done. She stated that she had first noticed the eruption on her chest about two months ago, and that a week later she observed that the skin of her feet and hands had become hard and thickened. At the same time the skin of her face and neck began to feel dry and hot. Her general health had been good.

On examination, the skin of the intermammary area was seen to be covered with raised follicular papules in the centres of which dark horny plugs could be seen. Though most numerous in the area indicated, these papules were also present on the rest of the trunk and the upper parts of the arms. The skin of the hands and feet was much thickened and of a dark brown colour; the finer lines had been replaced by deep, coarse fissures. Her scalp was covered with thick, whitish scales. The face and neck were reddened and scaly; this condition was particularly well seen round the ears. The nails were not affected.

The case seemed to be a fairly typical one of pityriasis rubra pilaris, the chief points of interest being the age of the patient and the association with pregnancy.

DISCUSSION.

The President said the diagnosis was not, in his opinion, open to doubt, but the case was exceptional in regard to its limitations to certain regions, the disease in his experience being usually more extensive in area. He did not think there was anything more than a fortuitous association with pregnancy. Pityriasis rubra pilaris was a very rare disease, whereas pregnancy was a very common condition. He hoped Dr. Barber would be able to show microscopic sections from the lesions in view of recent divergent views about them having recently been expressed at the Section.

Dr. Whitfield said he had not seen this disease in a pregnant woman before: he regarded the association as a mere coincidence.

Dr. PERNET said he thought it possible that there might be a connexion between the eruption and the pregnancy. The ætiology of pityriasis rubra pilaris was not known, and the rashes of pregnancy were very multiform.

Case of Dry Gangrene of the Toes in an Infant.

By J. H. SEQUEIRA, M.D.

PATIENT was a male child, aged 16 months, suffering from dry gangrene of the toes. The mother died four months ago in an infirmary from pulmonary tuberculosis, and the child had been much neglected. It was stated that there had been no previous illness, that the child had begun to walk when aged 11 months, but that since the toes had been affected he had not attempted to do so. Dentition had proceeded normally. There was nothing in the history to suggest exposure to cold, traumatism, or any obvious cause of the condition.

When the patient was admitted to the London Hospital the following lesions were present: On the left foot the little toe was affected with dry gangrene at its extremity, and chiefly on the plantar surface to $\frac{1}{6}$ in. below the distal margin of the nail. On the right foot the big toe presented a small area of dead black skin on the plantar surface. On the middle toe the area of gangrene extended from the end of the toe to one-half the length of the nail. On the little toe there was a patch of gangrene involving the pad at the end. The areas of gangrene were black, quite dry, and separation had taken place on the left little toe, leaving a healed surface. There was no evidence of acro-asphyxia and the skin immediately adjacent to the black patches was of normal colour. The skin elsewhere presented no abnormality. The fingers and the auricles were unaffected. There was no evidence of visceral disease. The child had put on flesh during the short time he had been in hospital, and was apparently in good general health; he slept and took food well. The parts had been kept warm by woollen socks and cotton-wool, but no other treatment had been necessary.

The exhibitor stated that neither at the London Hospital nor at the North-Eastern Hospital for Children had he seen terminal gangrene in an infant, and invited suggestions as to the possible cause. He regretted that the circumstances under which the child had been living prevented his giving a detailed account of the condition in its earlier stages.

DISCUSSION.

The PRESIDENT said he had not the least idea of the cause of the condition in so young a child. He assumed from Dr. Sequeira's account that there was no local asphyxia, such as that met with in Raynaud's disease, or other evidences of that condition.

Dr. PERNET said he had not previously seen a case of this kind in a child, but what occurred to his mind was the symmetrical gangrene of the extremities of Raynaud. In seeking for an ætiological factor, he noticed that the child's nose was depressed and the forehead prominent, so that the possibility of congenital syphilis should be entertained.

Dr. F. PARKES WEBER asked whether at the commencement the cyanosis was more extensive than corresponded with the final gangrene, only the worst parts becoming gangrenous. If so, he thought that it probably belonged to the group of Raynaud's disease in children, many of which cases were believed to be connected with congenital syphilis. In a few of the cases there were likewise attacks of paroxysmal hæmoglobinuria, which in adults might occasionally be connected with acquired syphilis, also with malaria. Some of the cases clinically classed as Raynaud's disease were possibly really due to syphilis or malaria, or to both combined, the vascular spasm occurring as a temporary condition—at the commencement of an attack—and perhaps never recurring after the onset of the distal necroses.

Dr. DOUGLAS HEATH said the case appeared to him to be more like the necrosis found as the result of disease of peripheral blood-vessels in adults than the result of cold. In his experience, when there were broken chilblains and frost-bites it was the dorsum of the toes which was involved, and similarly the dorsum of the fingers. The occurrence of an end-necrosis favoured its being due to arterial disease. He thought it quite likely that there was a congenital syphilitic element in this case.

Dr. WHITFIELD said he was not familiar with Raynaud's disease at this age, but at present there was no blueness or cyanosis at all. He had had under his care one or two cases of Raynaud's disease, and when they were not actually in the paroxysmal stage they remained with very blue hands. This child seemed to have a good circulation. With regard to the site of the gangrene, the child might have tried to walk on cold slabs, and then the tips of the toes would be in contact with the cold surface. But he thought there was something more about the case than simple exposure.

Postscript.—The Wassermann reaction which has been tested since the child was shown at the meeting has proved negative.

Bristle from Hair-brush with Ova of *Hæmatopinus Suis*.

By J. H. Sequeira, M.D.

Dr. Sequeira also showed ova of *Hæmatopinus suis*. The ova were large brownish-black "nits," attached by a collagenous collar to a bristle from a hair-brush. Dr. A. E. Shipley, F.R.S., had kindly examined the specimen and recognised the ova as those of the *Hæmatopinus suis*—the common pig-louse. The nits were much larger than those of the human head-louse, and had lost their opercula. The parasite did not attack the human subject. Dr. Sequeira was indebted to Lieut. A. C. Palmer, R.A.M.C., F.R.C.S., for the specimen.

Erythema Gyratum Recurrens.

By Alfred Eddowes, M.D.

The patient was a girl, aged 5, of strumous type. The lesions a week previous to exhibition were round, saucer-shaped, or perhaps better described as resembling a hot-water plate, the centres being concave, the edges raised quite $\frac{1}{8}$ in., the sides abruptly ending in the normal skin. The skin of the general surface was thin, and the patient was poorly nourished. This was the sixth attack in two years. Each attack had lasted about three months. One or both eyes generally suffered. Now it was the left that was affected. The mouth was slightly involved also. Such a definite type was rare. In Crocker's Atlas there was a good drawing and description of such a case, and there was also a good picture of it in the Sydenham Society's plates. The lesions, which were very striking, were usually few in number and tended to appear symmetrically; much of their typical appearance, so distinct a week previously, had changed already. Willis spoke of erythema annulare as a common form. It could not be that he had this type in mind when he made that statement.

Ringworm of the Hand.

By J. M. H. MacLeod, M.D.

THE patient, a middle-aged woman, presented a patch of eczematoid ringworm on the palm of the right hand, occupying an area about the size of a five-shilling piece, commencing between the first and second fingers, and spreading out in a ringed fashion over the palm. The patch was smooth, pinkish-red, broken up by an inner concentric ring, and limited by a border of exfoliating epidermis. The woman had come to the Victoria Hospital for Children with three children, all suffering from microsporon ringworm of the scalp, and it was presumed that they were the source of the infection. Though cases of eczematoid ringworm, due to the *Epidermophyton inguinale*, were by no means uncommon, the infection of the adult by microsporon ringworm was exceedingly rare, and the exhibitor could only recollect three such cases in his hospital practice. An examination of a piece of the exfoliating epidermis showed an abundance of fungus, but its exact nature had not yet been ascertained, as there had been insufficient time for the culture to grow when the case was exhibited.

The exhibitor considered it probable from the concentric appearance of the lesion that the fungus was of animal origin, and was possibly the microsporon of the cat, but he would report upon it later if a culture were obtained.

DISCUSSION.

Dr. GRAY said he had observed two cases of eczematoid ringworm of the palm, and in both of them the organism was an ectothrix.

The PRESIDENT said that some time ago, when this question was a burning one, Dr. MacCormac and he had investigated many eczematoid eruptions on the hands in which an epidermophyton was discovered, which would previously, without microscopic examination, have been considered as examples of vesicular or dysidrotic eczema.

Dr. SEQUEIRA said he had just reviewed a small paper by Dr. Murray and Dr. Paul, of Sydney, Australia, and these authors said that vesicating eruptions of the dysidrosis type were found to be associated with a fungus in 80 per cent. of the cases; they insisted on the importance of an examination for fungi in cases of dysidrosis.

Dr. DORE thought that Sabouraud did not recognise an ectothrix cat ringworm, but included it in the *Microsporon lanosum* group. Apparently Sabouraud regarded the cat microsporon as rare in France, and described the ectothrix form as *Trichophyton niveum radians* of the *Ectothrix microides* group.[1]

Dr. PERNET said that in 1904, at the old Dermatological Society of London, he had shown a case of tinea circinata in a young adult woman, who had contracted it from a cat. It was a case of cat microsporon, an observation which he had confirmed by culture.[2]

Case of Hyperidrosis of the Palms.

By H. G. ADAMSON, M.D.

(Shown by T. P. BEDDOES, F.R.C.S.)

THE patient, a girl, aged 16, had had the complaint as long as she could remember. There was profuse and continuous sweating of the palms and the palmar surface of the fingers of both hands. Changes of temperature seemed not to affect the condition. The perspiration was so profuse that the sweat dripped from the hands. Neither the soles nor any other part of the body was affected. From time to time large vesicles formed about the fingers and burst, leaving sore places. It was proposed to treat the case by X-rays "filtered" through an aluminium screen.

DISCUSSION.

The PRESIDENT said that all members of the Section had seen cases of this condition, although perhaps not quite so extreme. One case, which had impressed itself upon his memory, was that of a medical man who had a severe sunstroke in Japan, and, after recovering from that illness, hyperidrosis developed and persisted permanently. When he entered his (Dr. Pringle's) consulting room, sweat was oozing through his boots, as if he had been wading in a stream; it also oozed through his gloves, and he remained permanently disabled in consequence. He also had seen the case of a well-known public man who, when about to make a speech, sweated much as this girl did, although in the intervals, when nothing occurred to make him nervous, his sweat apparatus was quite normal. He regarded the prognosis as bad, and he would

[1] Sabouraud, "Les Teignes," 1910, pp. 229, 376, and 377.

[2] *Brit. Journ. Derm.*, 1904, xvi, pp. 347 and 458.

like to hear suggestions as to the treatment of such extreme instances as he had mentioned. The temporary benefit of X-rays in cases of less severity was an undoubted fact.

Dr. SEQUEIRA said he had seen the condition almost as severe as in the present case. It was notoriously difficult to treat. He followed Crocker in giving large doses of sulphur in some cases, though he could not trace much benefit from that treatment. Occasionally he had seen improvement follow the application of X-rays, but there was not so much benefit in this type of case as in excessive sweating in the axilla, &c. He had seen hyperidrosis on an area of the forehead which had previously been the seat of herpes, and it persisted for a long time after the herpes disappeared. He had seen unilateral sweating, which was set up by the stimulation of acids. Both those facts pointed to a nervous origin of the condition.

Case of Lichen Spinulosus.

By E. G. GRAHAM LITTLE, M.D.

THE patient was a girl, aged 10. The history furnished by the mother was to the effect that the eruption had appeared for the first time twelve months ago on the knees, and had slowly progressed since that date to occupy the present positions. The parts chiefly affected were the summits of the shoulders, the posterior wall of the axillæ, the back and front of both the elbows, the outer aspect of the thighs from the level of the buttocks to the knees, and the back and front of the knee-joint. Two kinds of lesions were to be distinguished, a perfectly pale, colourless follicular papule with projecting spine, and a coarser, reddened acuminate papule exactly like the papule of pityriasis rubra pilaris. The reddened areas were chiefly noticeable on the front or extensor surfaces of the elbows and knees, the lesions elsewhere than in these positions being of the pale variety. There was no itching, nor were other subjective sensations in connexion with the patches noted. In view of some recent suggestions of the tuberculous associations of the disease, it might be of interest to note that the patient's elder sister had been operated upon for tuberculous glands; but there was no suspicion of tuberculosis in this patient.

DISCUSSION.

The PRESIDENT asked whether it was certain that this child had not got congenital keratosis follicularis. He thought, chiefly on the ground of the

distribution of the eruption, that this was possible, and that the original lesions had been modified by irritation. He saw nothing resembling lichen planus papules.

Dr. LITTLE replied that no part of the eruption was congenital, and no other member of the family had any similar disease.

Case of Pityriasis Rosea.

By E. G. GRAHAM LITTLE, M.D.

THE patient was a Jewish boy, aged 10. The eruption was unusually scaly and erythematous, and on the back there were some darkened scaly patches contrasting with the vivid pink of the greater part of the rash. There was no history of a pioneer patch, and the whole eruption had come out acutely nine days previously. It was principally present on the trunk, with a few scattered patches on the upper arms and thighs. It was moderately itchy. The unusual degree of scaling made the diagnosis of seborrhœic eczema a possible one, but the distribution, acute onset, and colour favoured the diagnosis of pityriasis rosea; in corroboration of this was the fact that there had been some premonitory symptoms of sore throat, and headache, and there was considerable and general glandular enlargement.

Dr. LITTLE had seen an unusual number of cases of pityriasis rosea recently in his two skin clinics, and asked whether that was the experience of others. December and January he found were the months of most frequent incidence.

DISCUSSION.

Dr. SEQUEIRA agreed with the diagnosis.

Dr. EDDOWES confirmed Dr. Little's observation that pityriasis rosea was very prevalent in London.

The PRESIDENT agreed with the exhibitor's views. The type of eruption was that which Dr. Little and he used to discuss when Dr. Little was his clinical assistant fifteen years ago, and which gave rise to difficulties of differential diagnosis between acute seborrhœa and pityriasis rosea. He had now come to the conclusion that many of the conditions he then thought to be acute seborrhœa were really unusually inflammatory pityriasis rosea. Superficially the condition was almost like psoriasis. He had seen a case of this kind irritated by a chrysarobin treatment into general exfoliative dermatitis.

Case of Parapsoriasis-en-plaques.

By E. G. Graham Little, M.D.

The patient was a young girl, aged 12. The most characteristic of the patches was situated on the upper and outer part of the right thigh, where an area the size of the palm of a man's hand was to be seen, with a faint rose colour and a slightly serpiginous margin, and an almost imperceptible infiltration, so that the whole affected area was slightly swollen and raised. The follicular orifices were unduly patent in this region, but there was no spiny papule. There was no subjective sensation complained of in the affected parts; similar patches were present on the opposite thigh, on the buttocks, on the legs, and on the summit of the shoulders. The condition had persisted for over twelve months, and had recently been considerably altered by treatment with a strong salicylic acid ointment continually applied.

Lymphadenoma with Glandular and Cutaneous Lesions.[1]

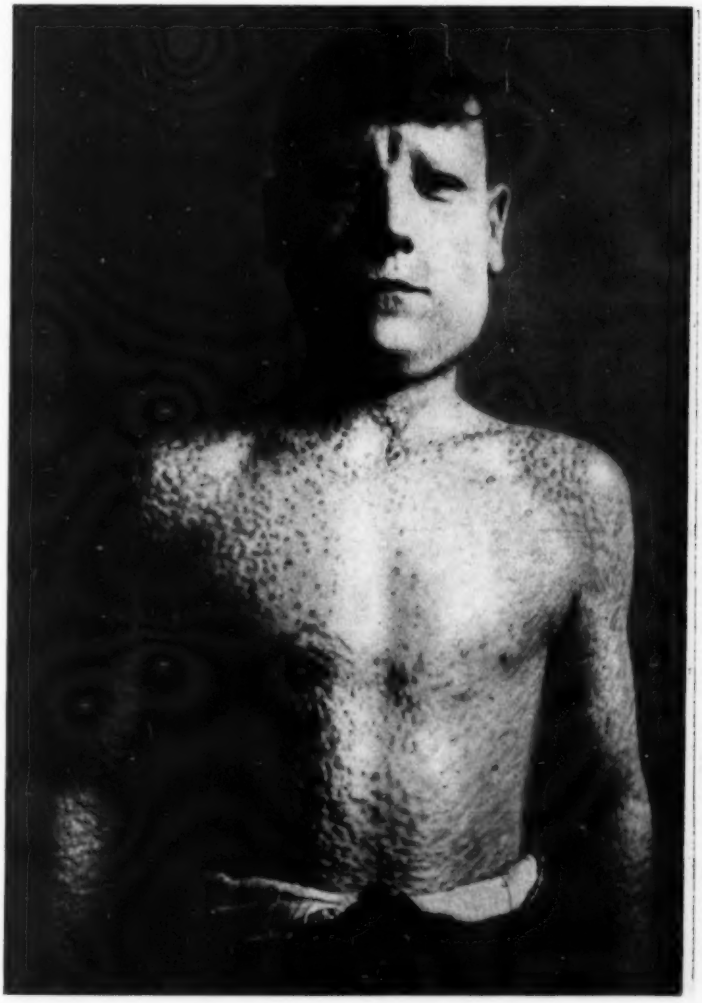
By W. Knowsley Sibley, M.D.

This case had been shown at the meetings of the Section held in June and October, 1914, when it was referred for investigation and report to the Pathological Committee. Since that date the patient had been taking arsenic internally and had had several applications of X-rays to the tumours over the occipital region, the enlarged glands in the sides of the neck, and to that in the left groin, and also to the skin over the left arm, forearm and hand.

In December the patient had had a severe attack of herpes zoster gangrænosa, preceded by considerable pain over the left lower ribs, which had left extensive and deep scarring. He had also from time to time complained of pain in the distribution of the median nerves, which disappeared on omitting the arsenic for a day or two. At the present time he was taking 12 minims of liquor arsenicalis, three times a day after food.

There was a very considerable improvement in his general condition. The skin lesions were much less marked, though the actual local appearances varied considerably from time to time, almost from day to day. The tumour-like formations on the back of the neck had completely disappeared, and all the enlarged glands which had been treated with X-rays had considerably decreased in size.

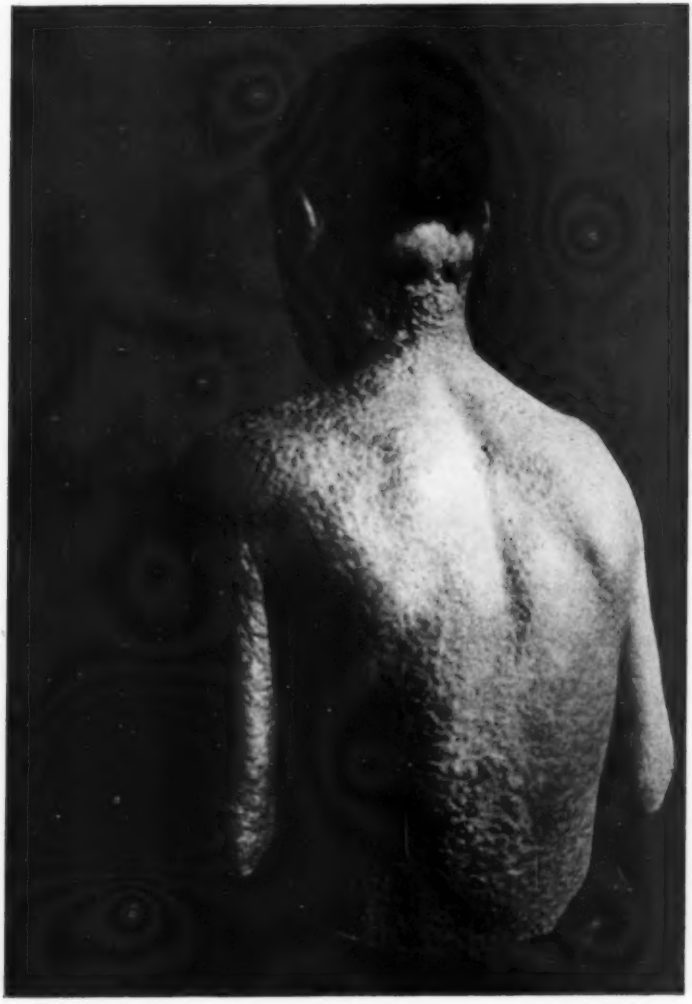
[1] The full report of the Pathological Committee on this case is published (*see* p. 63 *et seq.*).



Dr. Knowsley Sibley's case of lymphadenoma with glandular and cutaneous lesions.

FIG. 1.

Taken on October 21, 1914, showing enlarged glands in neck, and general eruption over chest and arms.



Dr. Knowsley Sibley's case of lymphadenoma with glandular and cutaneous lesions.

FIG. 2.

Taken on October 21, 1914, showing tumours on back of neck, and general eruption over the back.

Dermatological Section.

February 18, 1915.

Dr. J. J. PRINGLE, President of the Section, in the Chair.

Case of Multiple Tumours.

By E. G. GRAHAM LITTLE, M.D.

FROM clinical evidence alone the exhibitor had regarded the case as one of fibrosarcoma, but microscopical examination proved the tumours to be due to chronic fibrosis of the fat zone. The patient, a gentlemen, aged 49, gave an extraordinary history. Fifteen years ago he was treated, first in Turin and later in Geneva, with hypodermic or intramuscular injections of "phosphorus," ordered for a nervous affection from which he was supposed to be suffering. He had about fifteen injections of this, given every alternate day, some by the doctor and some by himself. Nodular swellings had resulted which had persisted for fifteen years and latterly had increased in size. In one or two instances there was slight redness round the tumour, but for the most part there was no inflammation, and the patient suffered hardly any discomfort. There were about twelve tumours, each about 2 in. by 1 in. in size, in the form of flat masses of induration which affected the whole thickness of the skin and were movable with it over the subjacent tissues. The diseased area could be lifted up, and formed a thickness of about ½ in., and one of these which was excised confirmed the clinical impression. The surface of the mass was, except in one or two instances mentioned, of the same colour as the surrounding skin, and was slightly puckered. The tumours were distributed on the upper parts of both buttocks and on the inner and upper surface of both thighs. These were also the sites of the injections, according to the history. The masses were extraordinarily hard and firm, and felt very like fibrosarcomata. One of the smaller tumours from the buttock was excised and sections cut from it, and examined by Dr. Kettle, Pathologist to St. Mary's Hospital, who furnished the following report:—

"Sections were taken through the greatest diameter of the nodule

and from the surrounding fat, and were stained in various ways. Unfortunately it was not possible to make satisfactory preparations stained for fat, as the specimen had been sent for examination put up in alcohol. The skin seems healthy and shows no change of any importance. The tumour presents a very anomalous appearance. It is composed, for the most part, of a very dense fibrous tissue which contains few fibroblasts, and shows little or no evidence of activity. Occasionally, especially at the deeper margin, there are groups of mononuclear cells, but the main mass of the tumour appears to be quiescent. Imbedded in this fibrous tissue are large groups of irregular cells varying very much in size and shape, and having a vacuolated cytoplasm and a compressed, deeply staining nucleus. Sometimes these cells are larger, denser, and multinucleated. These groups of cells occur especially in the more superficial zone of the tumour and its deeper part, and they appear to be invading the normal fat at the periphery, either independently or in association with prolongations of the fibrous tissue. They are, I believe, fat cells of the embryonic type. The appearances may be explained, I think, by regarding the condition as one of chronic inflammatory fibrosis associated with regeneration of fat. In the central parts the inflammation is old, but at the periphery there is some fibroblastic reaction and cellular infiltration pointing to an active process, although there is no evidence as to its nature. The formed vessels show a considerable degree of sclerosis, also suggestive of an old inflammation. Even so, the fat reaction seems to me to be highly peculiar and difficult to explain, for it appears to be present in advance of the inflammatory area. The tumour is not a fibrosarcoma, but there is just the possibility that it might be a highly atypical form of liposarcoma. In the absence of any localised mass of growth, however, this is scarcely likely, and I should not care to suggest such a diagnosis without much stronger evidence. Under the circumstances, I think the condition must be regarded as a chronic inflammatory one, of unknown origin."

Expressions of opinion were invited as to the prognosis and treatment.

DISCUSSION.

The PRESIDENT (Dr. J. J. Pringle) remembered having seen one apparently identical case, which was diagnosed after microscopic examination as multiple fibro-lipomata; but there was no history of previous puncture or other traumatism. There were six growths present, and they were successfully removed by a surgeon.

Dr. PERNET said he had never seen a similar case, but it reminded him of one something like it under Radcliffe Crocker a number of years ago. The patient attended once only, and no microscopical examination was made. Radcliffe Crocker's suggestion was that the tumours might be due to drug-taking. There had been no injections, as in the present case.

Dr. MACLEOD agreed that the obvious feature in the case was a fibromatosis, which was well marked in the hypoderm about the fat lobules. He was unable to express an opinion from the section exhibited as to whether there was a new lipomatous formation. He considered it quite possible that the fibromatosis might have been set up by the injections.

Two Cases of Dermatitis Factitia.

By GEORGE PERNET, M.D.

Case I.—A female patient, aged 23, with a number of superficially ulcerated and irregularly shaped lesions, and the remains of older ones and scars, about the upper hemisphere of the left breast. The process had been going on for a year on and off. There was a history of similar lesions in the same situation three to four years previously. There was also an ulcerated lesion on the right leg. According to the patient, the individual lesions lasted three months, then fresh ones appeared. There was very marked tenderness in the supra- and infra-mammary areas on the left side, but no ovarian tenderness. Some anæsthesia of the left border of the tongue was also present a few days previously, but there was no pharyngeal anæsthesia. The patient was left-handed in a general way for rough work, but she used her right hand for writing.

Case II.—A female patient, aged 30, with a history of three years and four months' duration. The condition was said to have been started by the accidental discharge of shot into the left forearm. Now the extensor surfaces of the left upper limbs were occupied by irregularly shaped, superficial ulcerations, crusts and scars. The individual lesions get quite well, but break down again when the patient resumes work. On the left side, from the shoulder and curving down over the left breast, were a number of scars, hypertrophic, irregular in shape (lozenge, angular and elongated), and reaching on the shoulder to near the spine of the scapula (within radius of fingers of the right hand thrown over left shoulder). On the left side of the body, in the mid-axillary line and about the region of the last ribs, were the remains of

recent lesions superficially reddened, and also the remains of older ones. The patient was right-handed. A few days previously, on her second visit, she presented some recent more or less quadrilateral bullæ of the *pomme soufflée* type.

DISCUSSION.

Mr. SAMUEL said he would like to discuss these cases from a psychological point of view. He did not agree that all dermatitis artefacta cases should be called (as they were in some text-books) *feigned eruptions*. There were two chief classes of cases—viz. (*a*) the true malingerer, where the artefact was produced *consciously* for the sake of gain or freedom from work; (*b*) the other more common class of case—viz., the hysterical dermatitis artefacta. It was at first sight difficult to appreciate the reason for these hysterical manifestations. It was commonly said it was due to the desire to attract sympathy, or suggested the patient was devoid of reason. Mr. Samuel could only briefly touch upon the explanation, but, according to Freud, it was somewhat as follows: Freud regarded hysteria just as he did all the psycho-neuroses, as the result of conflict between factors of the sexual instinct in its broadest sense and that of herd instinct (i.e., the ethical code, customs, conventions, laws, &c., of the society the individual belonged to). In most normal individuals the sexual instinct was sublimated into useful social channels, but in the neurotic the sublimatory process was not achieved, and the inevitable conflict, with its accompanying emotional tension, took place in the patient's mind. This intolerable state of tension was got rid of by a process of *repression*, where the offending combatant—viz., the sexual instinct—was pushed back into the unconscious (it was noteworthy that most of the cases were young single girls with no outlet for the sexual emotion). Although repressed, the idea did not cease to exist, but, on the contrary, acted as a foreign body, constantly striving for exit and expression. It could not do this in consciousness owing to the repressing force (Freud's endopsychic censor), but did so indirectly in all kinds of ways, so long as the subject did not recognise it in its disguise—viz., by phobias, hysterical paralyses, anæsthesia, and artefacts—so that these manifestations could be looked upon as indirect expressions of the sexual instinct and emotion. Freud called them conversion hysterias (the idea converted into physical stigma). Being unconscious, the idea was not under the control of the will, so became dissociated and assumed an automatic action. It was obviously useless and unfair therefore to take the patient to task or confront them with the act which was automatic, just as functional anæsthesia and paralyses were dissociated. One must try to reach the unconscious by hypnosis and make suggestions in that condition; but these hysterics were hard to hypnotise, and even then one was only dealing superficially with the trouble, which would recur in other forms. The most rational treatment was that of psycho-analysis (a very long and difficult procedure requiring great experience and special technique), by which the submerged idea was reached and

made conscious. The patient was reintroduced to his conflict in consciousness and made to fight it out, assisted considerably by sublimating the striving instinct into useful social channels. One should never ridicule these poor sufferers or regard their symptoms as trivial.

Dr. GRAHAM LITTLE did not agree with Mr. Samuel's contention that patients should not be confronted with the accusation of self-mutilation when this could in fact be proven. He had been struck with more than one demonstration of the rapidity of cure when the patients knew that they had been found out.

Dr. F. PARKES WEBER thought that of all diseases related to disorders of the psychical system, artificial eruptions in young women most deserved study from the psychical point of view, and it would have been a great advantage if the followers of Freud's teaching had concentrated upon this subject much of their psycho-analytic investigations. It would be a great gain to be able to clear up the mysterious mental element in these cases.

Dr. PERNET replied that he agreed with some of the views which Mr. Samuel had expressed. In 1909 he read, in Philadelphia, a paper on "Psychological Aspects of Dermatitis Factitia."[1] Moreover, at the Salpêtrière, in the days of Charcot, he had seen many cases of hysteria. But he did not agree with Mr. Samuel's definition of hysteria as a conflict between primary instincts. Janet, in his "Automatisme Psychologique," discussed hysteria very fully. Dr. Pernet had suggested that in some of these cases there was perhaps an alternation of personality. As to Freudism, that was another story.

Case of Coccidiosis Avenerea, with Microscopic Specimens.

By J. E. R. McDONAGH, F.R.C.S.

MR. MCDONAGH read some notes of this case. The patient, a big and healthy-looking man, aged 22, was brought to him by Mr. Drew (Oxford), complaining of a rash on his elbows and penis. When the rash appeared the patient was stationed in the North-west Frontier Province (India), and the following was the patient's account of the case. In August, 1914, he was playing hockey when he fell and cut both knees and the right elbow. A dressing was applied to the knees, but as the elbow wound was trivial no attention was paid to it. The knees healed quickly, but the wound on the elbow healed slowly.

[1] *Vide* Pernet, *Trans. Amer. Derm. Assoc.*, 1909; also the *Journ. of Cutan. Dis.*, New York, 1909, xxvii, p. 547.

Two months later a rash developed outside it and had been gradually spreading since. In September, 1914, the patient had what he called a "go of temperature," which lasted for three weeks. He had never had fever before, so the diagnosis made at that time was "fever following a frontier sore." Many doctors saw the sore on the elbow, and most were of the opinion that it was a "frontier sore." In November, 1914, a rash appeared on the penis, and a month later the left elbow became affected. The patient was treated with arsenic internally and various ointments were applied locally without any result.

When Mr. McDonagh saw the patient he was only on a few days' leave from the front, and it was on this account that he was unable to show the case. The lesion on the right elbow was a little bigger than a five-shilling piece; it was purple-blue in colour, slightly crusted in parts, and here and there were small depressed scars. The patch looked not unlike a sarcoid. Outside the patch were several irregularly distributed but discrete papules. The papules were about the size of a hemp-seed, red-brown in appearance, with somewhat of a transparent look, like the apple-jelly nodules in lupus. Some of the papules were crusted, a few had coalesced, but the base upon which they were situated was not inflamed. The rash on the penis and the left elbow was papular and indistinguishable from the papules just described. The papules on the penis affected the glans, the corona, and the under surface of the prepuce. When the under surface of the prepuce was stretched several papules were seen to be developing, so a portion of the tissue in this region was excised for microscopical examination. The patient had no enlargement of his lymphatic glands, nothing else abnormal could be discovered; he had never had sexual connexion, and the Wassermann reaction was negative in all dilutions.

Thinking the case was one of an infective granuloma, and probably protozoal in origin, he gave the patient potassium iodide internally and unguentum iodex externally, with the result that in four days' time there was a very distinct improvement.

Histological Examination of an early Papule. — Situated in the deeper layers of the corium was a circular cellular infiltration, about 1 mm. in diameter. The mass was perfectly circumscribed and there was no surrounding cellular infiltration. The mass might be said to consist of three parts: an outer layer of plasma cells, then a layer of mixed plasma cells, lymphocytes and endothelial cells, while the centre was mainly occupied by lymphocyte-producing endothelial cells. Hence the mass was not unlike a lymphoid follicle in a chronically inflamed

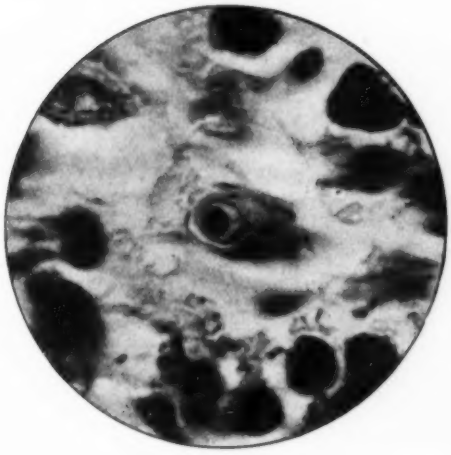


FIG. 1.

Trophozoite.

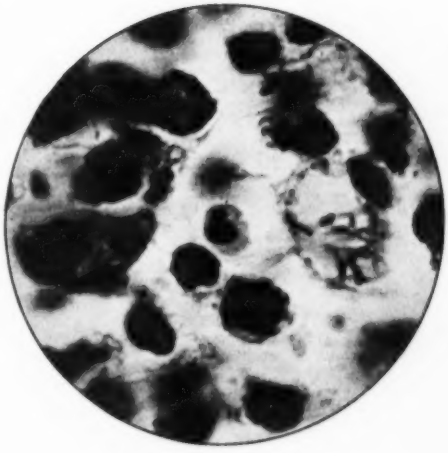


FIG. 2.

First division of trophozoite.

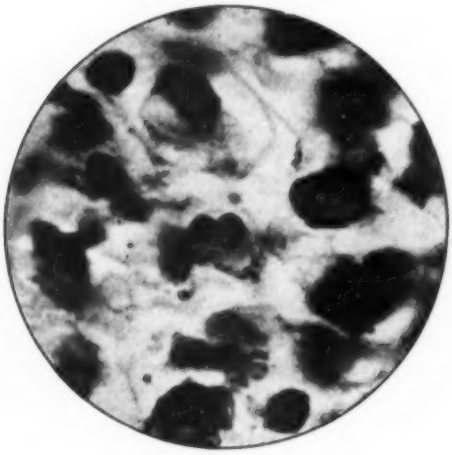


Fig. 3.

Development of trophozoite into merozoite.

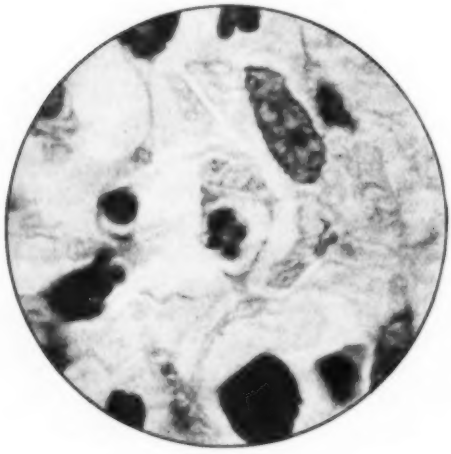


Fig. 4.

Development of merozoite into spores.

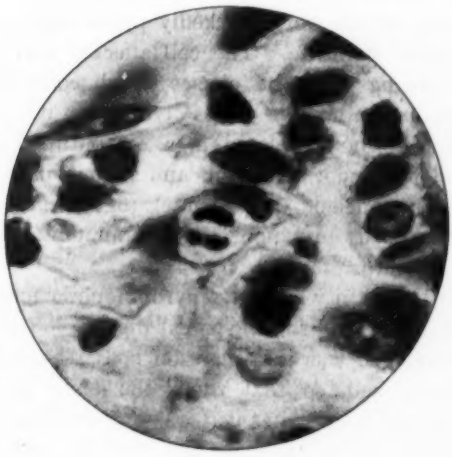


FIG. 5.

Intracellular development of spores.

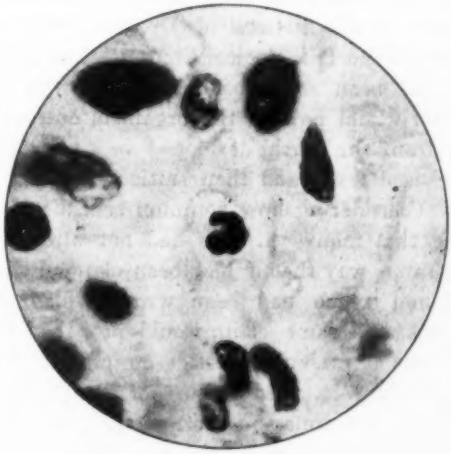


FIG. 6.

Extracellular development of spores.

lymphatic gland. Mainly in the intermediary zone were to be found some intracellular bodies, which were markedly pyroninophile, suggesting at once that they were parasitic. The cell affected was the endothelial cell, and the following were the phases which could be discerned:—

(1) A bright pyroninophile mass lying in its own unstained protoplasm, and the whole situated in a sac outlined by the edge of the protoplasm of the endothelial cell, and in one part by the concave inner surface of the nucleus (trophozoite) (figs. 1 and 2).

(2) An inclusion body in which the pyroninophile mass had become divided into two (merozoite) (fig. 3).

(3) Inclusion bodies in which the pyroninophile masses had further divided into four, eight, and so on (spores) (figs. 4, 5, 6).

The more developed was the inclusion body, the more degenerated was the endothelial cell, so that when the body had formed what appeared to be spores, it looked as if it was extracellular. The inclusion bodies were optically active, and gave the same microchemical reactions as the phases of the *Leucocytozoon syphilidis*, to the asexual stage of which they seemed to correspond.

In the opinion of the exhibitor the case was one of what might be called human coccidiosis, in which only the asexual stage was perpetuated. He had seen somewhat similar bodies to these in granuloma inguinale and in the sections of Dr. Sequeira's case which was recently submitted to the Pathological Committee of the Section.

From what had been said about this case, the most reasonable explanation to offer would be that the organism entered the wound on the right elbow from the earth, developed *in situ*, gained entrance to the circulation, caused fever, and then settled down in various areas to produce lesions. Considering how common coccidiosis was in animals, it was surprising that many varieties had not already been described in man. In the same way that it had been claimed that some cases of infective granuloma, which had been wrongly diagnosed as syphilis, were sporotrichosis, the same claim would probably be made out for coccidiosis. He was at present investigating certain primary syphilitic lesions, which were not followed by further symptoms, and which did not respond to treatment, unless it were in the form of iodine preparations. He had already come across five cases in which only the asexual stage of the *Leucocytozoon syphilidis* could be demonstrated.

Whether the parasite in these cases was really the *Leucocytozoon syphilidis* or some other coccidium remained to be seen. Anyhow, there were small differences in the various cases he had seen, which he hoped to give in fuller detail later.

Case of Favus of Glabrous Skin.

By S. E. Dore, M.D.

Dr. Dore said the case had been somewhat spoiled for demonstration purposes by treatment. The patient, a girl, aged 10½, presented two oval, erythematous, slightly scaly patches on the chin and right side of the neck near the angle of the jaw. There was also a similar lesion on the outer side of the right knee. When first seen the patches were indistinguishable clinically from circinate ringworm but for the fact that there was a typical favus cup in the centre of the lesion on the chin. He thought it was probably a mouse favus. Cultures and a stained microscopical specimen were shown. The mother said there were mice in the house, but the one she had brought him was healthy. The patient was English, and neither mother nor daughter had ever been out of this country.

DISCUSSION.

Dr. Adamson said that mouse favus in children due to *Achorion Quinckeanum* was fairly common in this country, and several members had shown examples. He did not think the culture exhibited by Dr. Dore was an *Achorion Quinckeanum*, which gave a more luxuriant white downy growth. It was not unlike a large-spored trichophyton culture, and he thought it might be the "trichophytiform favus," which had been described by Sabouraud, but not previously recorded in this country. It was not the ordinary *Achorion Schönleinii*.

Dr. Douglas Heath said he had had two cases of mouse favus, and the cultures he obtained from them were white and downy. The present culture was almost of a buff colour, and drawn in towards the centre, so it seemed different from the cultures of mouse favus with which he was familiar.

Dr. MacLeod said that he did not consider that the cultures shown were ordinary human favus, and thought that they were somewhat less fluffy and more yellowish than the ordinary cultures of the *Achorion Quinckeanum* of mouse favus. Before coming to a conclusion that the culture was a third fungus, he thought it would be advisable to grow it on Sabouraud's medium.

Dr. Graham Little suggested that Dr. Dore should grow the fungus on the recognised proof medium of Sabouraud, and bring another sample of growth under these conditions. He was not persuaded that this was not an atypical form of *Achorion Quinckeanum*, the unfamiliar nature being possibly conditioned

by the medium on which it had been cultivated. In early days, before the general adoption of the proof media, many varieties of the same species had been reported, the variations being subsequently shown to have depended on variations in the medium.

Dr. BUNCH said the cultures shown were, in his opinion, unusual, although he was inclined to think they more closely resembled the *Achorion Schönleinii* than the *Achorion Quinckeanum*. He agreed that it would be of interest to see what the culture would be when grown on Sabouraud's medium.

Case of Morphœic Sclerodermia.

By W. KNOWSLEY SIBLEY, M.D.

THE patient was a woman, aged 29. She had been married three years, and had one child aged nearly 2. There was nothing unusual in her family history, and no case of consumption had been known to occur in it. She had had scarlet fever and measles when a child, and was not in good health at the age of 15, when she suffered with patches of baldness. After a time the hair grew again on all the bald patches. For some years she had noticed "white spots" scattered over the upper regions of her chest. Of recent months these had considerably increased, both in numbers and size, many having coalesced to form larger areas. Similar spots had also appeared over her shoulders, sides of the neck, and on the ulnar surface of the forearms.

On examination, the upper regions of the thorax were seen to be studded with a large number of white spots which had the appearance of being small scars, as after an attack of acne. The spots were opaque, white, and glistening in appearance. Over the clavicular regions the skin was generally white and slightly infiltrated. The shoulders presented a somewhat similar appearance, with a marked patch of sclerodermia as large as the palm of the hand, situated in the intra-scapular region, where the skin was much infiltrated and wrinkled. There was a considerable increase of pigmentation in the skin in the neighbourhood of these white patches. White patches similar to lineæ atrophicæ occurred on the sides of the neck over the posterior border of the sternomastoid muscle up to the hairy scalp. Similar lesions occurred over the ulnar surface of the forearms. The lineæ atrophicæ on the sides of the abdomen were not very abundant, and were normal in appearance. There were no lesions present on the thighs or legs.

The patient had some half-dozen small patches of alopecia areata about the scalp, on some of which the hair was re-growing. The eyeballs were possibly somewhat prominent and von Graefe's sign was present. The thyroid was slightly enlarged.

DISCUSSION.

Dr. J. L. BUNCH said he had recently shown a similar case of morphœa guttata before the Section for the Study of Disease in Children in a child aged 12. He had been surprised to find how many French and American authors found it difficult to make a diagnosis between it and lichen atrophicus. No doubt there were, in some cases, resemblances; but in his opinion the differential diagnosis between the two diseases did not, as a rule, present very great difficulties. In both French and American literature considerable stress was laid on a history of tuberculosis in the patient, or his or her parents, but no such history was obtainable in his patient, and he asked Dr. Sibley whether his patient gave any such history. Dr. Bunch asked whether any section had been made, as the microscopical appearances already reported seemed to differ considerably.

Dr. F. PARKES WEBER asked whether members of the Section agreed that in these cases of superficial sclerodermia the tissue over and about the clavicles was one of the most frequent sites to be affected, as he thought it was. He asked whether definitely satisfactory results had been obtained from thyroid treatment in these cases. Thyroid treatment had been largely employed, or rather had been given a trial, in all varieties of sclerodermia, notably in the deep symmetrical diffuse sclerodermia specially affecting the extremities, before the onset of marked atrophic changes.

Dr. GRAHAM LITTLE, in answer to Dr. Parkes Weber, said that he had seen marked improvement with thyroid treatment in a case of extensive patchy sclerodermia, and the patient himself had been so satisfied of the improvement that, notwithstanding that he was obliged to remove to Derby, he continued to come up from that somewhat distant place in order to remain under treatment.

The PRESIDENT said it was undoubtedly very frequent for morphœa to appear first over and above the clavicles. In this case, he thought the association of alopecia areata with typical morphœa suggested the possibility of some endocrinic gland disorder, perhaps of the thyroid; and he drew attention to the presence of a distinct degree of von Graefe's eyelid symptom in the patient on the right side. The most perfect example of guttate sclerodermia he had seen — it was now the fashion to call it "white-spot disease" — was in a girl, whose case he exhibited to the Clinical Society twenty-nine years ago.[1] She had typical Graves's disease, and rapidly developed multiple, tiny,

[1] *Trans. Clin. Soc. Lond.*, 1886, xix, p. 313.

roughly symmetrical spots of morphœa. Three years previously she had had symmetrical alopecia areata. Many other such cases had been recorded in which thyroid gland disorder had been present, associated with morphœa. He had not, however, seen any convincing evidence of the efficacy of thyroid treatment, either of morphœic sclerodermia or of alopecia areata. It was remarkable how seldom these cases of the morphœic type merged into generalised sclerodermia, if they ever did so.

Dr. SEQUEIRA said he showed, some years ago, a lad who had the band form of morphœa, associated with the guttate form of sclerodermia, with herpetiform distribution on one side of the chest. The band on the leg extended from below the trochanter along the line of the sartorius and involved a great part of the leg. The guttate lesions were limited to the anterior half of the intercostal nerve areas.

Dr. PERNET agreed that the clavicular region was frequently an early seat of the condition. He believed he had had some results from administering thyroid extract. In a girl now attending the West London Hospital improvement seemed to have followed thyroid gland treatment; the effects were slow to make their appearance.

Mr. SAMUEL asked if members had noticed the prominence of the eyes, and queried whether the lagging of the eyelid noticed by the President would not be a contra-indication for treatment by thyroid extract. According to a recent article in the *Practitioner*, many cases of exophthalmic goitre developed into athyroidism and then did well on thyroid, and it was stated that in that stage the exophthalmos might still be evident, although the patient was actually suffering from deficient thyroid secretion.

Dr. A. EDDOWES said not only was the clavicular region a common early seat of the condition, but he believed the affection appeared more commonly on the left side than on the right.

Dr. SIBLEY replied that he had not been able to find any history of tubercle in the patient; sections had not been made. The main interest in the case appeared to be one of treatment. His experience of these cases, especially when there was much infiltration of the chest wall, was that they were all improved and often cured with local radiant heat treatment. He had begun that in this case, which was still in an early stage.

Case of Rodent Ulcer.

By E. G. Graham Little, M.D.

Patient, a man, aged 71, exhibited a rodent ulcer on the nape of the neck, and his case presented some interesting features. The history was that five years ago a "kernel" had formed on the neck which increased in size without ulcerating, until it must have been as large as a good-sized walnut, and then at the end of four years—i.e., twelve months ago—a portion of the tumour had ulcerated, leaving an intact portion at the upper and inner margin, which remained a typical waxy, mamillated rodent growth as big as a Barcelona nut. The ulcerated portion, in immediate continuity with this, was larger, and also presented the typical aspect of rodent ulcerations, the raised hard ridge surrounding the shallow excavation being particularly noticeable. No enlarged glands could be felt in the neck. A second feature of interest in the case, besides the unusual position, was the fact that there were numerous senile keratomata on the dorsum of both hands, and some on the face as well, and one in the latter position had begun to ulcerate, forming a second very small "rodent ulcer." There was no evidence, however, to show that the large ulcer on the neck had begun in the same way, on the site of a senile keratoma. Yet another feature of interest lay in the man's statement that his father had also had a chronic rodent ulcer of the same type as his own, but that he had lived notwithstanding this to the age of 95. This history and the rather advanced age of the present patient might suggest the propriety of regarding this as not a rodent ulcer but as a squamous-celled epithelioma, for it had been stated that rodent ulcerations with history of inheritance were very seldom seen. The exhibitor did not think the age was an important objection to the diagnosis of rodent ulcer and he had had several cases of probable inheritance. He was in full agreement with the opinion expressed by Besnier who had said that rodent ulceration might be the terminal form of many varieties of epithelioma, and he held that it was, in fact, a clinical term of great convenience, but did not connote a special cellular type, although, as Fox had pointed out long ago, general experience showed that growths clinically diagnosed as rodent ulcer exhibited singular uniformity in microscopical structure. Norman Walker had been rash enough many years ago to throw a challenge to the surgeons, "to many of whom," he said, "all

slowly growing epitheliomata were rodent ulcers, but that this view was shared by few pathologists"! But if rodent ulcer were essentially a clinical term, and this was all that could, in the exhibitor's opinion, be claimed for it, the two most characteristic differences which alone justified the making of a clinical group apart—and it must be remembered that the large majority of Continental writers did not follow the English school in this separation—were precisely this slow growth, and the absence of glandular invasions. By these criteria, and by the absolutely typical appearance of the lesion itself, this was undoubtedly a case of rodent ulcer. Dubreuilh, who had gone furthest of Continental writers in accepting the English view, attempted to withdraw from the rodent group cases showing senile keratomata and perhaps on these grounds would exclude this patient from that group, but—in the exhibitor's opinion—on insufficient grounds. But no connexion could be established between the rodent ulcer on the neck and the keratomata, although on the face there was a definite commencement of a rodent ulceration on the site of a keratoma. In opposition to Dubreuilh, the exhibitor was of opinion that senile keratomata were frequently associated with the development of perfectly indubitable rodent ulcers.

DISCUSSION.

Dr. ADAMSON said that this patient had undoubtedly multiple warty growths on the face and backs of the hands which were secondary to dermatitis solaris of these parts, but he would hesitate to say whether the large lesion on the back of the neck was one of these warty growths which had taken on a more active proliferation, or whether it was a true rodent ulcer of independent origin. A microscopical section would help. If it were a true rodent ulcer it would be probably a pure basal cell epithelioma; if a proliferated warty growth, it might still be basal cell, but would also contain horny cell-nests. He thought the term "rodent ulcer" should be limited to basal cell growths of embryonic origin and not arising on previously damaged skin. A difficulty arose from the fact that, although the majority of epitheliomata arising on previously damaged skin were squamous cell epithelioma, yet they might occasionally be basal cell and simulate rodent ulcer. They should be kept distinct, because they were ætiologically different and because they were much more likely to involve glands than was the true rodent ulcer of embryonic origin. As to the use of the term "epithelioma," it seemed to him convenient and correct to employ this for any epithelial growth and to preface it by the qualifications "benign" and "malignant."

Dr. MACLEOD said that he considered the case to be one of malignant epithelioma, probably due to the irritation of the actinic rays. He did not

believe that it was a rodent ulcer, by which he understood a locally malignant epithelioma growing chiefly from the basal layer of the epidermis, but thought it more probable that it had developed from the prickle cell layer. He considered that it was better to employ the name "epithelioma" in its full sense to include all the epidermal growths, benign or malignant, and not in the restricted sense in which it was commonly used in this country to signify a malignant growth of the epidermis capable of producing metastases.

Dr. SEQUEIRA said the point raised by Dr. Little was chiefly a question of terminology. The difficulty arose through the lax use of the terms "rodent ulcer" and "epithelioma." The lesion on the patient's neck was a carcinoma of the skin; whether basal-celled or squamous-celled was at present an open question. In some such cases the microscope was necessary to establish a diagnosis. He believed the pure pathologists were desirous of limiting the term "epithelioma" to innocent lesions, and of applying the term "carcinoma" to malignant growths with the adjectives "squamous-celled," or "columnar-celled," or "basal-celled." He had had cases of what Hutchinson called "crateriform ulcer"; forming button-like tumours, breaking down in the centre, and some of them were squamous-celled carcinomata while others were of the basal-celled type. The use of the term "rodent ulcer" was clinically convenient; he took it to mean carcinoma of the skin which did not cause metastasis, and ran a slow course. He would include in it a number of growths which started in the glandular elements of the skin.

Mr. MCDONAGH said that an epithelioma simply meant an abnormal growth of epithelium. The abnormal growth could be caused by inflammation or by a new growth. If the latter, then the prefixes should be added, so as to state whether the growth was benign or malignant. An inflammatory epithelioma could become a malignant epithelioma, but the diagnosis of the supervention of the latter should not rest upon whether the cells invaded healthy tissue or not, but upon whether they showed nuclear and nucleolar activity. It was best to divide up the new growths according to the layer of epithelium from which the growth arose. A tumour arising from the basal cell layer was a rodent ulcer and the most embryonic. A tumour arising from a layer or two above or from cells, which were destined to develop into one or other of the appendages, was less embryonic and formed what were called multiple rodent ulcer and epithelioma adenoides cysticum. A tumour arising from the middle layers of the rete Malpighii, or from one of the appendages, was what might be called a tumour of mature cell origin. Such tumours constituted the papillomata, tricho-epitheliomata, sebaceous adenomata and syringomata. In the speaker's opinion, a tumour arising from embryonic cells never became malignant, in the sense that it formed lymphatic gland enlargement and metastases. It never developed nuclear and nucleolar activity, therefore such a tumour was best described as merely exhibiting embryonic activity. Nuclear and nucleolar activity, or pseudo-parasitism, only appeared to involve mature cells, and when cells had passed their zenith and commenced

their decline their power of becoming malignant also declined. For instance, a so-called malignant epithelioma in which there were several cell-nests was less malignant than an epithelioma in which there were no cell-nests. The presence of cell-nests meant that layers approximating the stratum corneum had been attacked, and cells which formed horny tissue were partially degenerated.

Postscript.—Since this patient was exhibited another very similar case had been admitted to St. Mary's Hospital by Dr. Little's colleague, Mr. Cope, who kindly allowed him to see it. The patient was a man, aged 59, a greengrocer, living in London, and at the present time he had a large rodent ulceration, about 2 in. by 1 in. in extent, situated on the nape of the neck, somewhat to the left of the midline, in fact about half-way between the midline and the left ear. This began as a pimple twelve months ago, and ulcerated within a few weeks, and slowly increased in size to its present dimensions. He was treated with ointments. The ulceration was typical rodent, with the raised hard edge very marked, and very superficial ulceration. No enlarged glands could be found in the neck. On the dorsum of the hands and on the face there were a few patches of senile pigmentation, but without warty growth upon them. The whole growth had since been excised, and a careful search for enlarged glands in the triangles of the neck proved negative. A microscopical report of both of these cases would be submitted to a later meeting of the Section.

Case of Parakeratosis Variegata.

By H. W. Barber, M.D.

Mrs. H., aged 38, married, with two children, a shopkeeper. She stated that she had had nothing the matter with her skin until last summer. At that time, she thought towards the end of June, some red, somewhat scaly patches appeared on her legs. They were intensely irritable, and she scratched them a good deal. In August she went to the country, where her legs got very much better. In September she returned to town, and then her face, neck and arms became involved as well as her legs. She consulted her doctor, who treated her with ointment and medicine, and she said that the eruption seemed to be clearing from her neck, forehead, arms and the backs of her legs. In summer she perspired a great deal, and her skin was always worse and

more irritable when she got hot. Her general health was good, except that she was liable to fits of depression.

Description of the eruption: On the cheeks the eruption assumed the form of a diffuse, reddish-brown coloration, suggesting the combination of an erythema with increased pigmentation. Here and there were scattered small, oval, white areas. On the forehead the erythematous element had partially disappeared, leaving irregular areas of pigmentation having a somewhat reticular arrangement. On the neck the appearance suggested parakeratosis variegata, this retiform arrangement being well marked. On the front of the legs were large slightly raised erythematous patches, while on the calves the reticular appearance was again seen, associated with considerable pigmentation. The rash was also present to a slight degree in the antecubital fossæ. The scalp was scurfy and the hair dry.

The exhibitor had shown the case as one for diagnosis. The only suggestion he could himself make was that it was a mixed and unusual case of Brocq's parapsoriasis. The lesions on the neck, backs of the legs, and antecubital fossæ suggested the retiform variety of that disease, while those on the front of the legs might represent parapsoriasis en plaques. According to the patient's own statement the condition of her neck and forehead had been formerly exactly the same as the present condition of her face, and in the same way the retiform appearance on the backs of the legs had succeeded a condition resembling that now seen on her shins. If his suggestion as to diagnosis was correct, then the marked involvement of the face, the severe itching and the marked pigmentation, would in his own limited experience of the disease be exceptional features. He wished to acknowledge his indebtedness to Sir Cooper Perry and Dr. Sturdy, who had kindly permitted him to show the case.

DISCUSSION.

Dr. MACLEOD agreed with the diagnosis of parapsoriasis and drew attention to the similarity in the type of the lesions and arrangement of those situated about the root of the neck to the case exhibited and reported by Dr. Colcott Fox and himself,[1] under the heading of "Parakeratosis Variegata." This case, which had been under observation for a considerable period, had proved completely resistant to all forms of local and general treatment which had been tried.

[1] *Brit. Journ. Derm.*, 1901, xiii, p. 319.

The PRESIDENT said he agreed with Dr. Barber that the case was one of "parakeratosis variegata," as the reticulated appearance and ribbony, band-like lesions on the neck were rather characteristic of that condition. He well remembered the first three cases of the disease brought to the old Dermatological Society of London many years ago, and their being called "lichen dubius" by Dr. Payne and Dr. Cavafy in nomenclatural dilemma. After the publication of Unna's, Santi's, and Pollitzer's observations in 1890 their name of "parakeratosis variegata" had been generally adopted until the disease was claimed to be a form of the rather inchoate condition called "parapsoriasis." As a clinical term, he had always rather favoured Crocker's term "lichen variegatus." Itching was certainly a prominent symptom in some cases. He had now a case under observation which was rapidly going from bad to worse, and he knew of nothing which mitigated the severity of the disease in any way.

Mr. SAMUEL called attention to the classical description of parapsoriasis of Brocq as to the total absence of subjective symptoms; but nearly all the cases he had seen had had itching. A patient whom he had placed under the care of Dr. Gray for some time complained of intense pruritus, and that was the only complaint which induced the patient to seek treatment. In that case the quartz lamp had been employed for some time, and the patient was doing remarkably well as regards the pruritus, all other methods of treatment having failed to give relief.

Case of Dermatitis Artefacta.

By J. M. H. MACLEOD, M.D.

THE patient was a neurotic girl, aged 18, employed by a firm of lithographers. The part affected was the dorsum of the right hand, the dermatitis extending for some distance on to the fingers and up to the wrist. The lesions consisted of bullæ which were round or oval in shape and varied in size from a sixpence to a shilling, and which, on drying up, left scabs and clean-cut ulcerations which, on healing, were replaced by superficial scars. The whole of the affected area was covered with these lesions in different stages of evolution. The patient had been operated on at Charing Cross Hospital four weeks ago for a ganglion on the right hand which had been excised; some dermatitis had followed the healing of the excision wound; about a fortnight later the blebs began to appear and she was transferred to the Skin Department. The character of the lesions at once suggested an artefact, and the appearance of fresh lesions beyond the limits of an occlusive dressing and the healing of those beneath it corroborated the opinion.

The agent employed in the production of the lesions was uncertain, but it was probably some powerful caustic. The possibility of its being bichromate of potash, which was used in cleaning lithographic plates, was considered.

DISCUSSION.

Mr. SAMUEL asked whether it was not a fact that the skin of hysterics was more susceptible than the normal skin.

The PRESIDENT said there appeared sometimes to be "epidemics" of the psychical condition which led to the simultaneous production of cases of dermatitis ficta in considerable numbers. He had seen such pranks played by several members of one family; and in one case under his care in hospital the materials used for producing the lesions (small fly blisters) were actually supplied by the parents, who were nevertheless greatly indignant at his diagnosis when it was explained to them.

Lichen Planus of Unusual Chronicity.

By J. H. SEQUEIRA, M.D.

W. T., AGED 42, a carpenter, came to the London Hospital on February 9, 1915, on account of an eruption upon his legs. He had had small-pox thirteen years ago, but in other respects his health had been good. Twenty-five years ago an eruption of spots appeared on the front of both legs. The affected parts itched, especially at night, and occasionally, if knocked, an area has broken down to form an ulcer. The eruption consisted of a number of shiny, flat-topped, raised areas, varying in size from a millet seed to patches ½ in. long by ⅓ in. across. The small lesions were characteristic of lichen planus in their colour, their burnished surface and shape. The larger areas were evidently caused by fusion of the elementary lesions. These were raised above the surrounding skin about one line, and had a lilac-tinted surface. Some spots were covered with horny scales, but the majority were smooth. The areas involved were the anterior and the antero-internal surfaces of both legs. The thighs, arms and body were free. The buccal mucosa was also unaffected. The treatment carried out during the twenty-five years had been the application of ointments and lotions.

The case was shown on account of its unusual duration; and, in view of the difficulty he had himself experienced in the treatment of similar cases, the exhibitor invited suggestions from members of the Section.

DISCUSSION.

Dr. GRAHAM LITTLE agreed that treatment of these conditions by X-rays was usually very unsatisfactory, but he had had considerable success with freezing. In the most hypertrophic case of lichen planus which he had ever seen, and which he had shown to the Section, the patient, a woman of middle age, had warty growths as big as the distal phalanx of a man's thumb, about twelve of these being situated on the right leg. The growths had been carefully pared with a very sharp razor until sensations of pain began to be felt, and then the surfaces treated with carbon dioxide snow. All the growths had in this way been reduced till they were flush with the surrounding skin, and a very good flat scar resulted. The process had occupied about six weeks, the number of lesions to be treated preventing the application of the "snow" to all at a single sitting.

Dr. ADAMSON said that lichen planus hypertrophicus was generally very intractable. In his experience X-rays had not given good results in spite of full doses frequently repeated. Other treatments he had employed without success were: application of salicylic acid plaster, protection by plasters or bandaging, mild cauterisation with trichloracetic acid, and freezing with carbon dioxide snow. But he had not used the snow after shaving off the growth as Dr. Little recommended. He had lately had good results from nitrate of silver stick dipped into water and rubbed on to the patch. Hypertrophic lichen planus was not infrequently associated with varicose veins, and in that case supporting bandages helped to remove the skin eruption.

Dr. DOUGLAS HEATH said the application of X-rays stopped itching, and he was in the habit of applying strong elastic pressure afterwards. In hypertrophic eczemas strong elastic pressure led to much shrinkage of the lesions.

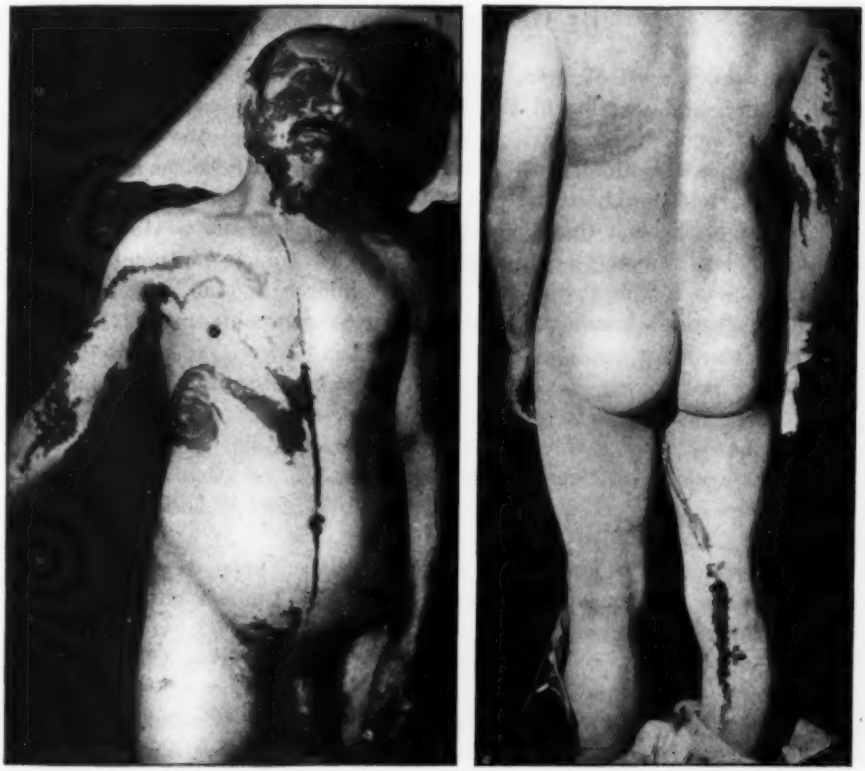
Dr. CORBETT suggested ionisation followed immediately afterwards by X-rays. The combination had been successful in cases of warts which had resisted treatment with either agent separately. The ionisation apparently acted by causing a local hyperæmia, rendering the tissues more sensitive to the X-rays.

Dr. DORE agreed that such cases did not yield readily to X-rays, but he had had two cases in which that treatment had been successful.

Case of Nævus Linearis.

By Dudley Corbett, M.D.

The case was of interest on account of the extensive distribution of the nævus growth on the face and neck, and its linear configuration on



Case of nævus linearis.

the trunk and limbs, especially the vertical line extending almost exactly in the midline from the claviculo-sternal junction to the symphysis pubis. Thence it was directly continuous down the back of the right thigh and knee, following the ventral axial line in that limb.

The PRESIDENT asked if there was any history of other members of the family being similarly affected, and referred to the well-known Lambert family in which the disease existed in male members of the family throughout at least four successive generations.[1]

Case of Tertiary Syphilis.

By GEORGE PERNET, M.D.

A WOMAN, aged 57, with extensive tertiary gummatous infiltration, ulceration, and scarring of the skin of the right leg, which had commenced some fifteen years previously, starting about the part above the right external malleolus. There were also similar lesions about the upper part of the chest and the root of the neck. The interest of the case lay in the fact that the patient had never had any treatment, but for the last fifteen years had merely applied boracic ointment. The patient was a widow who had had ten children and no miscarriages. The husband appeared to have died from general paralysis of the insane.

[1] *See* article "Ichthyosis Hystrix" in Allbutt and Rolleston's "System of Medicine," 1911, ix, p. 23.

Dermatological Section.

March 18, 1915.

Dr. J. J. PRINGLE, President of the Section, in the Chair.

Two Cases of Alopecia in Children due to Over-doses of X-rays.

By J. H. STOWERS, M.D.

THE patients exhibited were two male patients, brothers, aged 11 and 4 respectively, who had been subjected to X-ray treatment for tinea tonsurans by an electrician holding no medical qualification. Pastilles were used, and the exposures were stated not to have exceeded an hour, but dermatitis followed. Although five and a half months had elapsed since the treatment, considerable bald areas remained upon the scalp of each child, which, in the exhibitor's opinion, were likely to be permanent.

The cases were instructive as indicating the extreme importance of guarding against excessive exposure, and especially when it was remembered that the scalps of some children were less tolerant of the effects of X-rays than others, this constituting one of the difficulties of dermatological practice.

The cases were sent by a medical practitioner to Dr. Gray for an opinion and, in his absence, were seen by Dr. Stowers.

DISCUSSION.

Dr. DUDLEY CORBETT said the amount of damage varied in different regions of the scalp in both cases. In the more shiny parts he did not expect any re-growth; but such was possible where the scalp was less damaged and more freely movable over the underlying tissues. He had treated two or three such cases by means of the mercury vapour lamp and there was certainly

some improvement in the texture of the areas of scar tissue, and some re-growth of hair over the less damaged areas. These accidents, he thought, were partly due to the employment of soft tubes.

Dr. SIBLEY thought it was too soon yet to give a positive opinion as to the likelihood of re-growth of hair. He had seen alopecia persist for many months after the application of X-rays, and then re-growth occur. In those parts where there was cicatricial tissue he did not think there would be re-growth, but in other areas it might take place. He recently had a case at the hospital of alopecia following ringworm two years previously. No X-rays had been applied in that case, and he remarked that if X-rays had happened to have been used on that head all the delay in re-growth would have been attributed to that agent. In one of the cases shown there was scarring and telangiectasis, which rendered recovery improbable; but the hair might reappear on the other areas.

Dr. G. PERNET said he saw not long ago a case in which X-rays had been applied and alopecia persisted for a considerable time, but eventually there was re-growth. There was not any shininess of the scalp, however. He agreed that the outlook in the present cases, as far as the shiny cicatricial areas were concerned, was bad; but the other areas might recover to some extent. He advised a stimulating lotion.

Cotton-seed Dermatitis.

By J. A. NIXON, M.B.

WORKERS in certain kinds of grain were known to be liable to an eruption which was believed to be caused by a "mite" called *Pediculoides ventriculosus*. Barley appeared to be the particular grain which harboured this insect, so much so that the disease was commonly called "barley itch." The exhibitor had recently seen a similar complaint attacking workers in cotton seed. In January, 1915, he was consulted in reference to an outbreak of an irritable rash amongst some of the dock labourers in Bristol. The only labourers affected were said to be engaged in unloading a cargo of cotton seed consigned from Alexandria to Bristol. After several unsuccessful attempts he was fortunate in seeing a man whose eruption had only just appeared and which still remained unaltered by scratching and secondary infection.

T. T., a healthy dock labourer, aged 42, had enjoyed good health all his life, and had only drawn six weeks' sick pay from his club in fourteen years. He was not liable to food rashes and presented no

sign of scabies or body-lice. His history of the present condition was that three days before seeing the exhibitor he had been at work unloading a cargo of cotton seed (in bulk) from Alexandria. Within a short time of starting work on the cotton seed the patient began to feel some irritation about the neck and arms. This irritation increased and became most severe during the following night when he got warm in bed. At first no rash could be seen, but towards evening a series of red spots, about the size of mosquito bites, appeared at the site of the irritation. Some of the spots developed "bladders" upon them which burst and discharged a watery fluid. He had previously had similar attacks, the first occurring some four or five years ago, but the present attack was the worst he had suffered from. The patient stated that he had developed a somewhat similar eruption from working in "itchy" barley.

The rash died out in a week if not renewed by continued work in the "cotton seed," or unless it was "scratched and poisoned," when a "sort of eczema set in." The rash did not appear on the covered parts of the body. The spots were not transient or recrudescent. There must be actual contact with the seed before the itching started; mere entrance into the place where the seed was stored did not cause any itching. It was only certain cargoes of cotton seed which were "itchy"; the men thought that the "itchy" cargoes were those which came from Alexandria; there had been no complaints with those from Smyrna. But cotton seed if in bags did not seem harmful; it was only when handling cotton-seed cargoes "in bulk" that the "itch" occurred. Of fifty men working on this cargo about two-thirds had been attacked.

The eruption consisted of sparsely distributed isolated urticarial papules situated chiefly on the neck and forearms with a few papules on the legs. Each papule was pinkish-red in colour, hard, raised, and about the size of a pea. In its general appearance the rash resembled a moderately severe attack of lichen urticatus in a child. There were no burrows of the *Acarus scabiei* to be seen.

A microscopical examination of the cotton seed showed that the dust was infested with a living parasite closely resembling if not identical with *Pediculoides ventriculosus* as described in Stelwagon's "Diseases of the Skin," and in Dr. Shipley's articles on "Insects and War" in the *British Medical Journal*.[1] *Pediculoides ventriculosus* was held to be the cause of "barley itch," and Dr. Nixon thought it would

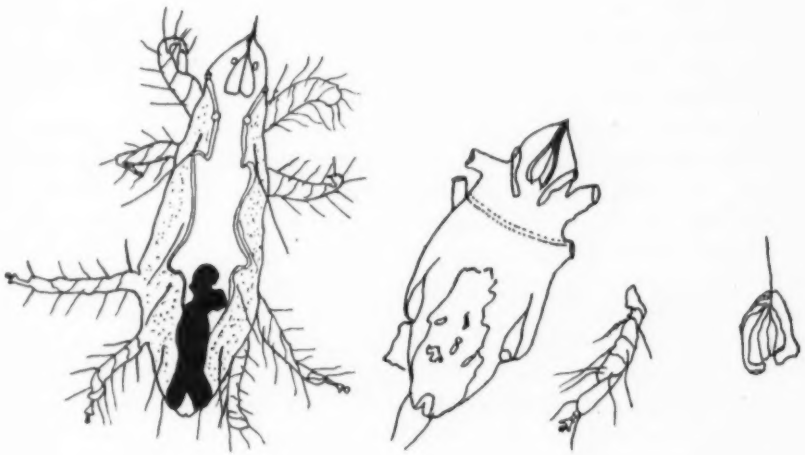
[1] *Brit. Med. Journ.*, 1914, ii, p. 751.

be proved that the parasite exhibited that evening, and at present unidentified, was the cause of the papular urticarial eruption described under the name of "cotton-seed dermatitis."

Dr. W. D. Henderson, Lecturer in charge of the Department of Zoology at the University of Bristol, thought that the "mite" found in the cotton seed submitted for examination seemed to be very closely allied to the *Pediculoides ventriculosus*, but he very much doubted if it was identical with it. His report ran as follows: "The animal is elongated and flattened dorso-ventrally, with an average length of 0·165 mm. and an average breadth of 0·068 mm. It is sharply pointed at the anterior end and more rounded at the posterior end, and has four pairs of walking legs. The cephalothorax is marked off from the abdomen by a slight groove, and increases in size from before backwards. The two anterior pairs of walking legs rise at some little distance apart, but the two posterior pairs, which rise close together, are at a considerable distance from the anterior pairs. The first pair of walking legs differ slightly from the posterior pairs in the distal joint. The three posterior pairs of legs are apparently seven-jointed, and the tarsus is markedly more slender than the other joints and has its terminal portion in the shape of a small cone-like structure. About half-way up the tarsal joint there is a pair of peculiar lateral outgrowths which gives the tarsus a †-shaped appearance. Each of the joints of the leg seems to carry only a pair of stiff hair-like bristles. The first pair of walking legs differ in the following way from the others: the terminal joint does not end in that peculiar cone-like structure, nor has it the lateral outgrowths; it ends in a claw-like structure. The penultimate joint also carries a larger number of hairs than any of the proximal joints, and certainly a larger number than any of the joints of the other three pairs of legs. The cheliceræ are apparently reduced to stylet-like structures which are capable of protrusion. The pedipalps are also greatly modified and partially fused with the maxillary plate, but they terminate in a hard claw-like lip. There are two well-marked tracheæ which are arranged near the lateral margins. Near the anterior end, close behind the base of the pedipalps, rising near the basal joint of the anterior pair of walking legs and running obliquely forwards till they reach the exterior, there is a pair of peculiar channel-like structures which may be only a modified portion of the tracheal system or may be the pseudo-stigmatic organs. With reference to the internal structure, I should not like to give any definite details, as all the specimens were dead when they reached me. Another point which I

am still very doubtful about, is the exact number of hairs borne on the body. As far as I can judge at present there seem to be from three to five pairs. The males are much shorter and broader, but there was not any very good specimen, so the description must wait till more fresh material is procurable."

Dr. Shipley has kindly submitted a specimen to Mr. C. Warburton, who writes of it thus: "I think Dr. Nixon may have got the culprit. It is so excessively small that unless alive it would be very hard to find. His mite is one of the Tarsonemidæ. Banks[1] quotes Karpelles as



A, dorsal aspect; B, majority of specimens found in this condition; C, one of the posterior walking legs; D, anterior end of mite showing a stylet-like projection.

saying of a mite of the same group infesting barley in Russia, 'The men had been handling barley and the mites spread from this to the hands, when they caused an irritating inflammation of the skin so intense as to force the men to leave their work.'"

[1] "Treatise on the Acarina," p. 77.

Acarus from a Case of Copra Itch.

By A. Whitfield, M.D.

Dr. Whitfield showed an acarus from a case of "copra itch." He said that he was sorry that he was unable to show the patient, but the disease disappeared very rapidly under treatment. He was not previously aware that the disease occurred in London, and he had been surprised that cases had not been shown by those in charge of the Dermatological Departments at either the London or Guy's Hospital, as their practice would naturally bring them more into contact with dock labourers than those farther west.

The patient in his case was a stevedore, who had had two attacks. The rash was generalised all over the trunk and extremities, but did not affect the face. It was very much like that described by Dr. Nixon, and consisted of numerous single and grouped follicular papules, so that at a casual glance it looked like seborrhœic eczema. By the kindness of Dr. Corner he had been able to obtain some of the copra. The acarus was not found all over the surface of it, but there were small eroded cavities in the pulp in which the acarus was to be found, and which were evidently eaten out by the acarus. It was difficult to mount a very satisfactory specimen as the material was so greasy, and the acarus was very delicate. Eventually under a low power he had been able to isolate the specimen shown, but in doing so he had broken off a leg or two. He had not found the disease described in any text-book that he had referred to for it.[1]

DISCUSSION.

Dr. Graham Little pointed out that Castellani had described in detail[2] a very similar if not identical acarus in copra, which was responsible for eruptions in workers in that material, and the entomology of the parasite had been successfully established.

[1] *Postscript by Dr. Whitfield.*—Subsequent to the meeting, at the suggestion made by Dr. Little at the meeting, he had consulted Castellani's book and found an accurate description of the disease, and figures of the parasite. The latter was evidently identical with that shown by Dr. Whitfield, and was classified by Castellani as *Tyroglyphus longior* Gervais, var. Castellani.

[2] *Brit. Journ. Derm.*, 1913, xxv, p. 20.

Dr. J. M. H. MACLEOD said that he had seen a case of copra dermatitis at Charing Cross Hospital about a month ago in a man who was unloading copra which he said was much decomposed, and, when turned over, emitted a cloud of fine dust. On the face there was an acute erythematous condition, with swelling of the eyelids, while on the hands and arms there was a papulo-vesicular dermatitis, the lesions being irregularly distributed, some discrete, others clustered or aggregated into crusted patches. (A note on the case had been sent to the *British Journal of Dermatology* previous to the meeting.) Referring to Dr. Nixon's case, Dr. MacLeod said that about eighteen months ago a number of cases of dermatitis had occurred in men unloading a cargo of cotton seed at the London Docks. The outbreak was investigated by his colleague, Colonel Alcock, of the London School of Tropical Medicine. The dermatitis somewhat suggested the lesions of lichen urticatus. An examination of the cotton seed revealed numerous small caterpillars of the cotton moth (*Gelechia gossypiella*). Living on these caterpillars were small mites, which Colonel Alcock recognised as the *Pediculoides ventriculosus*, the parasite of grain-itch, and he considered that the dermatitis was due to this mite. He believed that its presence on the cotton seed was contingent on the presence of the caterpillars on which it was a parasite.

Case of Severe "Blood Mixture" Eruption in a Patient with Primary Syphilis.

By GEORGE PERNET, M.D.

THE patient was an ill-nourished man, aged 40, who first attended at the West London Hospital on February 12, 1915, for a severe characteristic iodide eruption of the face mainly. The lesions were large and raised, mixed up with smaller typical ones. When asked if he had taken any "blood mixture," the patient admitted he had taken two bottles of Clarke's Blood Mixture for some spots he had on the face. According to Martindale's "Extra Pharmacopœia," this nostrum contains 52·5 gr. of iodide of potassium to 8 oz., so he had taken some 100 gr. of the drug. On examining the patient, a primary syphilitic sore of the end of the prepuce, giving rise to a phimosis, was discovered. Numerous *Treponemata pallida* were found on examination of the sore. The Wassermann reaction was positive (Dr. Elworthy, Pathologist to the West London Hospital). The patient was warned to take no more blood mixtures. Neo-salvarsan 0·4 was ordered, and circumcision recommended to start with, but the patient did not present himself

again till March 2. On March 3 the neo-salvarsan was administered. There was nothing wrong with the urine. Now the iodide lesions had flattened down considerably, leaving marked pigmentation, a common event in such cases, apart from arsenic. The neo-salvarsan had probably acted beneficially on the drug rash.

DISCUSSION.

Dr. A. WHITFIELD said he did not doubt the condition was an iodide rash, because the nodules on the face were very large ones. Syphilitic nodules of that size would have left marked atrophy, whereas iodides, unless the rash was very suppurative, left extraordinarily little change in the skin.

Dr. F. PARKES WEBER asked whether it was usual for iodides, apart from syphilis, to cause such a degree of purpuric erythema and pigmentation. He suggested that the peculiar eruption in this case was partly due to secondary syphilis.

The PRESIDENT said it was remarkable that such cases were not more frequently seen, as the sale of Clarke's Blood Mixture was very large. He did not doubt that the rash on the face was due to an iodide; the deep pigmentation was peculiarly characteristic of such an eruption, during its involution.

Dr. A. EDDOWES said if the patient had had arsenical preparations the pigmentation might have come about in that way. He had seen a case of acute secondary syphilis mistaken for psoriasis, and arsenic had been given in the usual routine way by a practitioner. The result was that every lesion became deeply pigmented, and it took a long time for the colour to disappear. It also set up acute paronychia and aggravated the eruption.

Dr. PERNET, in reply, said that the man had not, when seen, taken any other medicine than Clarke's Blood Mixture. He had 0·4 of neo-salvarsan on March 3, but the pigmentation was then established. The urine was normal.

Case of Erythema Induratum of Bazin.

By GEORGE PERNET, M.D.

THE patient was a small, overworked girl, aged 15, who attended the West London Hospital. She began five weeks previously to suffer from aching in the legs. When first seen there was a typical erythematous, indurated condition of both calves, which could still be felt.

The condition, however, had much improved, the patient having been put on to less laborious work with opportunities of rest, and she had been taking syr. ferri iodidi since first seen on January 22. There was no history of phthisis and no chilblains, but the circulation was below par, exhibiting itself in an erythema marmoratum of the front of legs and bluish hands.

DISCUSSION.

The PRESIDENT said the case was a very characteristic example of a familiar condition. He exhibited the first typical case he had seen in a girl, aged 14, to the Dermatological Society of London in January, 1890 (before its Proceedings were published), and again in January, 1895,[1] when the lesions had ulcerated. Although the nature of the disease was even then quite clearly recognised by dermatologists, his surgical colleagues refused to accept any diagnosis other than that of syphilis. The classical papers on the subject by Hutchinson[2] and Colcott Fox[3] among British observers, were doubtless well known to all members of the Section, and had popularised expert knowledge of the subject among the profession, by whom it was now almost universally recognised.

Dr. GRAHAM LITTLE said he had at St. Mary's Hospital at present a very similar case, also in a young girl, aged 14, with more numerous lesions, scattered over the front and back of the lower third of the legs. The induration area had materially diminished as a result of rest in bed. This patient had given a marked reaction to a test inoculation of tuberculin, for after the injection of $\frac{1}{2}$ c.c. of old tuberculin the temperature had risen to 103° F.

Case for Diagnosis (? a Tuberculide).

By W. KNOWSLEY SIBLEY, M.D.

THE patient was an unmarried servant girl, aged 18, whose parents were living and well. She was the fourth of the family, and had three brothers and four sisters, all of whom were healthy. There was no history of consumption in the family. The disease commenced on the upper lip two years ago, and was stated to have followed a cold, with discharge from the nostrils, after an operation for adenoids. Small dull

[1] *Brit. Journ. Derm.*, 1895, vii, p. 28.

[2] *Arch. of Surg.*, 1895, vi, p. 8.

[3] *Brit. Journ. Derm.*, 1893, v, p. 225.

red papules first appeared on the upper lip; these after a time slowly spread towards the cheeks, and afterwards appeared on the tip of the nose. For some months they had remained more or less stationary, and had never suppurated or broken down and ulcerated.

On examination, there was some slight seborrhœa capitis, and a few small comedones on the face. The papules were very hard to the touch, markedly raised, and were arranged singly and in groups, being especially abundant on the upper lip, and irregularly symmetrical on the cheeks, and on the tip of the nose and the free margin of the alæ nasi. They were very prominent and superficial, of a dull red colour, with a yellowish glistening surface, and varied in size from a pin's head to a small pea. Under pressure with a glass they revealed greyish-yellow foci. Many of the older ones showed a distinct puckering with a tendency to a central depression and a dilatation of the superficial blood-vessels, with some slight scaling on the surface. A few had disappeared and left small atrophic scars. The whole upper lip was slightly thickened, and there was some excoriation and fissuring of the vermilion. The glands of the neck were slightly enlarged. The von Pirquet reaction was negative on three occasions.

The patient now had an acute attack of lymphangitis of the face. She stated she had previously had a similar attack.

The blood-count was as follows: Red blood cells, 4,800,000 per cubic millimetre; white blood cells, 5,200 per cubic millimetre. (There were no abnormal red blood cells.) Differential leucocyte count as follows: Polymorphonuclear cells, 61·5 per cent.; lymphocytes—large, 7·5 per cent., small, 29·5 per cent.; eosinophiles, 1 per cent.; basophiles, 0·5 per cent. The count showed a lymphocytosis, and a slight diminution in the polymorphonuclear leucocytes.

Section of small nodule taken from the face: The epidermis was practically normal, except over the diseased area, where it was very thin and flattened out. In the dermis there was a nodule, which was composed of badly stained endothelial cells, separated by bands of fibrous tissue; there were also a few giant cells present. The whole nodule was more or less surrounded by fibrous tissue. The upper portion of the dermis outside the nodule was infiltrated chiefly with lymphocytes. There were no plasma cells nor mast cells to be seen. The vessels showed a marked dilatation.

DISCUSSION.

Dr. ADAMSON thought the clinical and microscopical appearances were those of a typical lupus vulgaris. The case was a severe form of that type in which there appeared rather suddenly a shower of "apple-jelly" nodules on the skin of the nose and adjacent part of the cheeks, and in which the prognosis was usually very unfavourable. He regarded the swelling of the cheeks and eyelids as due to a secondary streptococcal infection.

Dr. WHITFIELD agreed with Dr. Adamson that this was true lupus, with probably streptococcal lymphangitis. He had a figure of such a case in his book; the patient also had recurrent erysipelas and scattered nodules. His opinion was that the streptococcal lymphangitis spread the disease a little each time it occurred. The scattered type was very apt to be secondary to a primary focus elsewhere, and it would be interesting to know what was the condition inside the nasal cavity. The section seemed to be typical lupus, though he did not know that one could swear to tubercle on microscopical examination only. There were ill-formed giant cells, and, what was characteristic of tuberculosis, commencing degeneration. He considered this case belonged to the endothelial type of lupus.

Dr. DORE asked whether Dr. Sibley had examined the gums, as he thought they were affected with characteristic lupus vulgaris.

Mr. MCDONAGH said he considered the case was one of lupus vulgaris—that was to say, a case in which the bacilli themselves were present, in contradistinction to a lesion caused by their toxins. The microscopical section he saw, which the exhibitor had sent to him for an opinion a few weeks previously, was doubtless external to a papule, as it did not show the characteristics of either tuberculous or any other inflammation. One could only say from the section examined that it was from a case of chronic inflammation.

Dr. DOUGLAS HEATH said that while agreeing that this condition was tuberculous, he dissented from the view that it was common to see such superficially set lupus. He agreed that a nodular condition was met with, particularly in lupus of the nose, but in the present case the nodules were more superficial than usual.

Case for Diagnosis.

By S. E. Dore, M.D., and S. A. Kinnier Wilson, M.D.

Dr. Dore said that the patient, a man, aged 54, was sent to his department at Westminster Hospital, suffering from pain and swelling of the fingers and toes with changes in the nails; and as there was not much to found a diagnosis upon from a dermatological standpoint he asked his colleague, Dr. Kinnier Wilson, to see him. The latter found the patient had well-marked thermo-anæsthesia of the toes, feet, and half-way up the legs, and suggested the diagnosis of lepra. The patient's history was as follows: He was born in Kent of healthy parents. In the year 1888 he visited South Africa on two occasions, spending about fifteen months there altogether. From 1889 to 1893 he was employed as a steward in the P. and O. Steamship Company, and travelled to and from India, staying about three weeks on shore, usually at Calcutta or Bombay, at each visit. His symptoms dated from eighteen months ago, when he noticed a swelling under the nail of his left index-finger which he attributed to pressing down hot tobacco in his pipe. About the same time the nail of the middle finger became affected and both fingers were swollen and painful, especially during cold weather. Two months later he complained of "itching down the spine," followed by similar symptoms in the toes, and blisters appeared between the latter. By slow degrees all the finger nails of both hands became affected with longitudinal splitting of the nail substance, the fingers themselves being blue, tender and œdematous, with marked thickening and roughening of the skin over the first phalangeal joints and great sensitiveness to cold. The toes were affected in a similar manner but to a less degree, and there was some patchy pigmentation of the shins attributed to slight injuries. The patient had also suffered from pain in the chest and back and left shoulder. The result of the Wassermann test had not yet been obtained, but the exhibitor thought that a positive reaction would be a strong point in favour of lepra as against syringomyelia. Unfortunately, Dr. Kinnier Wilson was unable to be present and a complete account of the nervous symptoms was therefore not forthcoming.

DISCUSSION.

The PRESIDENT said the evidence in favour of the diagnosis of leprosy appeared to him rather scanty. He had seen an identical condition of finger-nails in a case which his neurological colleagues diagnosed as syringomyelia. But he was quite open to conviction.

Dr. WHITFIELD said that if the Wassermann test was positive, it was an important point. He thought the man should be given a tuberculin injection, because if that proved positive also, the case was very likely one of lepra in the absence of obvious signs of tubercle. He had asked the patient if he had had burning, and he said he had a sensation in his fingers as if he had plunged his hand into a bed of nettles. That gave an extraordinarily good representation of the sensation experienced in lepra; he did not know whether it occurred also in syringomyelia.

Dr. F. PARKES WEBER thought the only alternative to the diagnosis of anæsthetic leprosy would be "Morvan's type of syringomyelia." Working in Brittany, in 1883, Morvan described a trophic disorder of the extremities associated with the formation of painless whitlows and areas of analgesia. When he (Dr. Weber) was attending Charcot's demonstrations in Paris, it had been definitely agreed that the so-called "Morvan's disease" was to be called "the Morvan type of syringomyelia." This had been settled by Charcot, Marinesco, Jeanselme, and others, in spite of Zambaco's suggestion that Morvan's cases were sporadic examples of attenuated leprosy occurring in Europe. In one or two of Morvan's original cases in which a post-mortem examination had been made no evidence of leprosy had been found. In the present case the fingers did not seem to be sufficiently bulbous to accord with the typical "Morvan type of syringomyelia." Moreover, the patient had never had "painless whitlows" such as Morvan described. His ulnar nerves at the elbows were perhaps slightly thickened, as in some cases of leprosy.

Dr. PERNET thought the case sufficiently important to ask for it to be brought forward again, when perhaps Dr. Kinnier Wilson could be present.

Case of Lichen Scrofulosorum in an Adult.

By H. G. Adamson, M.D.

The patient was a male, aged 18, who had also lupus vulgaris of the nose and caries of the spine. The case was shown as a striking example of this well-known tuberculide. The lesions consisted of oval patches made up of groups of red-brown follicular papules of the size of a large pin's head. There were four patches on the abdomen and two on the back, each measuring about 1 in. by ½ in., and made up of some fifteen to twenty papules.

DISCUSSION.

The President did not think that the case could be considered as "ordinary," examples of lichen scrofulosorum being, in his experience, seldom seen in persons of adult age. It was certainly an eruption which would escape the diagnostic power of many persons but for the concomitant conditions of lupus and spinal caries. He remembered an excellent description of the condition in the works of Hebra, who described large papules in comparatively extensive circles, contrasting with the much more finely patterned lichen scrofulosorum of young children.

Dr. Adamson replied that he did not think in his experience that lichen scrofulosorum was more common in children than in adults; and cases as pronounced as that now shown were, he thought, more often seen after puberty.

Case of Macular Atrophy following a Secondary Syphilitic Eruption.

By H. G. Adamson, M.D.

The patient, A. C., was a man, aged 38, who had contracted syphilis six years ago, and in whom the secondary eruption had been followed by the present atrophic macules. He had first noticed the atrophic patches some ten or twelve months after the disappearance of the eruption, and no direct transition of the papules into atrophic patches could be proved in this particular case. There were now altogether

about a score of atrophic macules situated on the trunk, on the upper part of the back, the chest, and the abdomen. There were also two or three radiating from the axilla on its anterior fold, and one below the eye on the right cheek. They were rounded, or oval, with their long axis in the direction of the "lines of cleavage," and of an average long diameter of ½ in. They were of pale lilac colour, and gave to the finger the impression of a hole in the skin covered by a thin membrane, while on folding up the skin they could be made to bulge outwards from distension by the tissues beneath.

The particular interest of this case lay in its association with syphilis. Many examples had now been recorded of atrophic macules following a secondary syphilitic eruption. Erasmus Wilson, Colcott Fox, and Malcolm Morris in this country had demonstrated cases of macular atrophy after syphilitic eruptions, and Balzer, Fournier, Danlos, Mibelli, and Volk among Continental observers. The exhibitor had previously shown two cases of syphilitic origin, and had observed one other in addition to the present case. In two cases the atrophic macules had been associated with leucodermia syphilitica on the neck (Section of Dermatology, October 20, 1910, and June 15, 1911).[1] But syphilis was not the only known antecedent of this condition. Some cases had been associated with tuberculosis, and the exhibitor had shown the case of a phthisical person in whom the atrophic areas corresponded with groups of lichen scrofulosorum (Section of Dermatology, October 20, 1910).[1] Graham Little had brought forward a case of macular atrophy of the trunk, associated with lupus erythematosus of the face, and Thibierge had described a similar case. It seemed, therefore, that macular atrophy, once known as idiopathic macular atrophy, could be the result of various toxins, particularly of syphilis and tubercle —which produced these lesions by causing atrophy of the elastic fibres of the corium.

Dr. GRAHAM LITTLE asked if Dr. Adamson could say whether the atrophic patches had appeared in the sites of previous syphilitic lesions. In the case of macular atrophy with lupus erythematosus which Dr. Adamson had mentioned as having been shown by himself it had not been possible to establish the connexion between the atrophic areas and previous lupus erythematosus patches.

[1] *Proceedings*, 1911, iv, pp. 1, 122.

Case of Linear Nævus in Mother and Child.

By H. C. Samuel.

The patient was a married woman, aged 26, who had had two children. She came complaining of the condition of her forearm and neck about four weeks ago. The lesions looked like flat warts, but more careful examination showed the condition to be linear nævus. He showed the patient because of the lateness of onset of the condition —it developed in her sixteenth year on the chest and axilla—and there was a long interval before its appearance on the neck and forearm—namely, not till the age of 25. He asked whether this condition usually followed the course of the superficial nerves, superficial vessels, or the lines of cleavage or metameres; also as to the best treatment. He believed that carbon dioxide snow had proved disappointing. The patient's daughter, aged 9, was beginning to exhibit the development of the same condition on the same side in the same situations.

DISCUSSION.

Dr. Adamson said that it was characteristic of linear nævus that it frequently did not appear at birth or in infancy, but often some years later, and even as late as puberty. In some cases the warty streaks continued to increase in size and number even after puberty, while in others they diminished or even disappeared entirely. He considered carbon dioxide snow the best treatment for this condition, but would apply it only to parts which were exposed or which caused inconvenience—not to the whole extent of the lesions.

Dr. Graham Little had had some success in treating warty nævi of this type with freezing with carbon dioxide snow, but had also had many disappointing results with the treatment.

Case of Generalised Atrophic Sclerodermia with Sclerodactylia.

By F. Parkes Weber, M.D.

The patient, Mrs. B. T., aged 44, a Jewess, was a rather slender woman of medium height. She presented a condition of symmetrical, very chronic, typical atrophic sclerodermia, involving her face, neck, and hands. The face, neck and region of the clavicles were covered by

atrophic, tightly stretched skin, marked by numerous blotchy and fine branching telangiectases, and showing characteristic pigmentary changes on the neck and about the clavicles. The hands were, however, much more severely affected by the disease, and furnished the characteristic picture of a late stage of *severe atrophic sclerodactylia.* The livid, shiny, atrophic skin was tightly contracted about the bones of the fingers, which were more or less fixed in various positions of contracture. She frequently suffered from superficial indolent ulcers (caused by any slight traumata) over the knuckles of the fingers; these ulcers were very painful and very slow to heal. There was no decided sclerodermia of the feet, that was to say, the disease in the feet had not yet reached the contracted, cicatricial, or atrophic stage, as it had in the hands; but the toes and distal portions of the feet tended to be livid and cold, and at present she was suffering from a superficial indolent ulcer over the left heel, which gave her much pain. She suffered also from occasional pains elsewhere in the limbs, but those associated with superficial ulceration on the heel and fingers were at times very severe, and often gave rise to sleeplessness at night (as most kinds of "ischæmic" ulceration of the extremities did). Her pains were, however, she said, temporarily relieved by taking aspirin. Dr. Weber could not feel any pulsation in the dorsalis pedis artery of either foot. Both radial arteries and both radial pulses seemed to be normal. The brachial systolic blood-pressure, estimated in October, 1912, was just over 100 mm. Hg. in both arms. Röntgen-ray skiagrams, taken by Dr. N. S. Finzi, in October, 1912, had shown decided general atrophic changes in the bones of the face and considerable atrophy of the finger-bones, especially of the terminal phalanges, almost all of which were shortened by actual disappearance of their tips. The patient's blood serum, in December, 1912, had given a negative Wassermann reaction for syphilis.

According to the patient herself, her illness commenced when she was aged 32, after the birth of a stillborn child. This was her fourth child. Her two first children were still living and healthy, aged 17 and 16 respectively. Her third, fifth and sixth children died in infancy. She had had no other children and no miscarriages.

Dr. Weber had had an opportunity of examining the patient during the past ten or eleven years on various occasions, when she was an in-patient at the German Hospital under the care of his colleague, the late Dr. K. Fürth. Thyroid treatment and subcutaneous injections of fibrolysin had been tried, but with doubtful results. Local hot baths

were, probably, more useful. When Dr. Weber saw her about 1904, before obvious sclerodactylia had developed, some of her fingers used occasionally (for a few days at a time) to have a swollen, shiny, slightly bluish appearance, a condition that might be termed "bluish acro-œdema," perhaps allied to the *œdème bleue* of Charcot.

This mode of commencement was perhaps one of the most interesting features in the case, which in many respects resembled that of a young woman shown in 1901 by H. D. Rolleston and S. Vere Pearson before the Clinical Society of London,[1] and shown again, in 1909, by H. D. Rolleston and G. D. H. Carpenter before the Clinical Section of the Royal Society of Medicine,[2] under the heading "Sclerodermia with Sclerodactyly."

It was highly probable in cases of sclerodactylia of the feet that (even in cases in which no pulsation in the pedal arteries can be felt), if one could examine small arteries such as the internal plantar and dorsal arteries of the foot, no true endarteritis obliterans, nor thrombosis, would be found, but only contraction and thickening (not merely apparent thickening) of the arterial middle coats. At all events, that would best accord with what the speaker found in the subsequent examination of the amputated foot of a young man, whose case he had described in the *British Journal of Dermatology*[3] under the heading "Trophic Disorder of the Feet—an Anomalous and Asymmetrical Case of Sclerodactylia with Raynaud's Phenomena."

Some of the cases of "trench frost-bite" or "trench foot" (French, *mal des tranchées*) amongst the soldiers in the present war seemed to present striking analogies with the condition of the foot in cases of sclerodactylia, especially with cases accompanied by a tendency to superficial gangrene, but before the atrophic (contracted) stage of the disease in the foot had been reached. The great ætiological difference between the two seemed to lie in the fact that in the former (trench frost-bite) the immediate exciting cause was a powerful and obvious one, whereas in the latter (sclerodactylia) the constitutional factor was apparently the main one, the immediate exciting cause being generally slight or obscure. There was naturally a corresponding difference in regard to prognosis. The greater the constitutional factor and the slighter and more obscure the exciting cause, the less favourable was

[1] *Trans. Clin. Soc. Lond.*, 1901, xxxiv, p. 215.

[2] *Proceedings*, 1910, iii (Clin. Sect.), p. 32.

[3] *Brit. Journ. Derm.*, 1901, xiii, p. 41.

the course of the disease likely to be. It was, however, possible that ultimately sclerodactylia would be found to be connected with some morbid action of the ductless glands or with the prolonged presence of some ergot-like toxin, either taken unknowingly with the food or manufactured constantly in small quantities within the patient's body (in his alimentary canal or in his metabolic organs).

Dr. STOWERS said he had failed to detect any abnormal pulsation in the arteries of the foot in such cases. The case which first attracted his attention to this disease was that of which coloured drawings were shown—possibly the most severe of all recorded instances—the hands and fingers having the same characteristics as Dr. Weber's patient but to a much severer degree. His patient, a married woman, dated her disease from a difficult confinement at the age of 23, her previous health having been fairly good. Soon afterwards she lost weight and complained of various subjective symptoms, during the existence of which her right hand and fingers became swollen and stiff. During the following five years the morbid process, still limited to the right hand, gradually developed, the skin over the phalangeal joints becoming inflamed with some discharge of pus from small ulcerations over the knuckles, and slowly contracting. By degrees the integument, at first tender and hypersensitive, became absolutely painful, sharp "flashes" of pain of a neuralgic kind starting from the finger-tips, radiating over the hand, and passing up the forearm. As months elapsed, the integument over each articulation again swelled and inflamed, so much so, that the least movement was accompanied by acute suffering. The skin did not present excessive pigmentation, the colour remaining natural, or of a reddish hue, the tightened and contracted state being observable at the extremities or pulps of the fingers previous to the extension of the state to the joints which followed during the next five years. As nearly as possible five years after the right hand became affected the left commenced to undergo similar changes. Besides the shortening and contractions of the fingers from bone absorption, all the joints, except the upper (metacarpo-phalangeal) of each thumb, became fixed. Skin changes of the same character, though less intense, involved the thighs and lower extremities. The disease gradually progressed, producing the following additional structural alterations —viz., the angular outline of the face, made conspicuous by the relative prominence of the malar bones together with the shrinking and falling in of the cheeks; the retraction of the eyelids, producing considerable space between the globes and their coverings; the shrivelling and irregular contractions, or crimping, of the lips. Besides these, the whole integument was dense, hard, and unyielding; the surface being dotted, here and there, with numerous small capillary telangiectases; and lastly, the existence, more particularly on each side of the forehead and towards the hair border, of marked excessive pigmentation. The patient died of pneumonia about the age of 55.

Case of Simultaneous Herpes Zoster of the Third and the Eighth Dorsal Segments of the Left Side in a Boy aged 11.

By E. G. Graham Little, M.D.

The eruption had begun in the lower segment, on the Saturday previous to the meeting; there had not been any preceding pain, the first symptom being the rash, and there were some six areas of typical herpetic vesicles stretching from the anterior midline to near the posterior midline, along the level assigned in Head's diagrams to the eighth dorsal. On the following Sunday and Monday the rash began to appear in the upper third dorsal segment in two large herpetic patches — one above the left nipple and separated from this by two finger-breadths, and one over the level of the spine of the scapula. Both these areas were well marked when shown, and there was in addition a small circumscribed reddened patch, without obvious vesicles upon it, on the middle of the inner surface of the upper arm. Pain had been considerable in this segment, being referred to the left axilla and along the length of the forearm. There were no aberrant vesicles, and the interval between the levels of the third and fifth dorsal segments was perfectly clear of all eruption. There was a rather obscure history which might have some bearing on the causation, the mother stating that the child had had a fall on the pavement while roller-skating on the previous Thursday, but that he had shown no bruising, though complaining at the time of the fall of some pain in the lower part of the back. There was no spinal tenderness along the whole line of the vertebræ.

The case was probably unique in the simultaneous evolution of the eruption in two segments on the same side of the body, separated by the wide interval represented by five segments. Head, who had probably had the largest possible experience of the eruption of herpes zoster, had never seen this phenomenon, although he had notes of one case, not published, in which the fifth dorsal on one side and the twelfth on the other side had been the seat of a simultaneous herpetic eruption.

DISCUSSION.

The PRESIDENT agreed that both eruptions were herpes zoster, and he was interested to hear that it was a unique experience to have two distinct segments affected on the same side.

Dr. GRAY thought it was fairly frequent for contiguous roots to be involved. Was Dr. Little satisfied that the intervening space was not affected? [Dr. LITTLE said that he was.] The best marked case of bilateral herpes zoster he had seen followed on an injection of salvarsan. On the third day after the injection typical lesions appeared on both ears, on the right side of the lower lip, absolutely demarcated by the middle line, and on the left margin of the tongue.

Mr. SAMUEL referred to a paper by Dr. Essex Wynter, in which he stated that 75 per cent. of the cases affecting the small nerve ganglia—i.e., the ganglia connected with intercostal nerves—occurred in children under the age of 14; while it was usually the larger ganglia which were involved in the herpes zoster of adults.

Dr. ADAMSON thought both areas were herpes zoster. He had not previously heard of two separate areas being affected on the same side.

Dr. DOUGLAS HEATH said he had tabulated a large number of cases of herpes zoster, but he had not previously seen or read of two areas being affected on the same side. He had never himself seen bilateral herpes zoster on the body.

Case of Dermatitis Herpetiformis.

By E. G. GRAHAM LITTLE, M.D.

THE patient was a boy, aged 8. The eruption had begun some fifteen weeks ago, with a bullous rash about the neck and the left groin, and the earlier diagnosis had been that of bullous impetigo. The case was lost sight of for some time, during which the application of ammoniated mercury ointment for several weeks had been attended by no improvement but by an extension of the rash, and when the patient attended again after the interval the diagnosis had consequently been altered to that of dermatitis herpetiformis. The present distribution was as follows: the neck and the left groin, the sites of the first appearance, remained the most affected parts; there was an area triangular in shape (with the base reposing on the line of the clavicles,

and the apex at the xiphoid) covered very closely with vesicles grouped for the most part in herpetiform manner and on a very inflammatory base, the whole area offering a fanciful resemblance to a red breast-plate studded with pearls. There was a crop of less inflammatory vesicles around the umbilicus, and there were several isolated, not reddened, bullæ about the abdomen. In the left groin more especially, and stretching across the base of the penis to the right groin another very inflammatory band studded with large bullæ was present; a similar highly inflammatory patch was found on the back of the neck and on the trunk between the scapular spines. Some bullæ grouped in a roughly circinate manner occupied the skin over the internal and external malleoli on both sides, and there were a few sporadic bullæ on the dorsum of the feet and behind the ears. The eruption was sufficiently itchy to disturb sleep, and the boy consequently slept in gloves to prevent scratching. There were no lesions on the mucosa of the mouth. Individual vesicles were mostly small, the size of a pin-head, and with frequent herpetiform grouping, but there were also numerous isolated bullæ much larger than this, some of these being of the size of half an almond. The contents of the blebs were for the most part clear. Several film preparations were stained for bacteria and showed only well-formed polymorphs and no bacteria whatever.

DISCUSSION.

The PRESIDENT agreed with Dr. Little that this was not impetigo, because if it were, with bullæ of so great size, the contents would have been pustular long previously. To draw a hard-and-fast line between dermatitis herpetiformis and pemphigus was, he now thought, impossible; but that point would be dealt with in the forthcoming debate on the pemphigoid eruptions. He did not think the accidental grouping of a few of the lesions constituted an essential difference between the two diseases. Somewhat in favour of Dr. Little's view was the itching, a feature which Duhring made much of. Unna's opinion, often quoted, that dermatitis herpetiformis in young children was confined to boys (*Hydroa puerorum*) was undoubtedly too absolute. He had himself seen two cases in young girls.

Dr. ADAMSON regarded this case as one of pemphigus vulgaris and not a very uncommon affection in children. The eruption usually cleared up when the patients were put to bed and given daily baths, though there was often a relapse if they were allowed to get up too soon. In some cases milder relapses recurred for a year or so, but all usually got well ultimately.

Dr. DOUGLAS HEATH said that in the cases of what he recognised as dermatitis herpetiformis in children the bullæ were generally large. In the adult, on the other hand, the lesions were often uniformly moderate in size. He agreed with Dr. Little's diagnosis. These cases were rapidly amenable to arsenic.

Mr. H. C. SAMUEL said that a point in favour of the diagnosis of pemphigus rather than that of dermatitis herpetiformis was the fact that the bullæ arose from normal skin instead of from an erythematous base.

Dr. LITTLE said, in answer to those who had expressed their preference in this instance for the designation of pemphigus, that in his opinion the separation of dermatitis herpetiformis was premature, but if it was to be accepted at all as a group apart from pemphigus this case was clearly and inevitably to be classified in that category. It seemed, in fact, to combine most of the criteria chiefly relied upon for differentiating dermatitis herpetiformis from other bullous diseases, as described in Duhring's original paper. The distribution in particular might be compared with that emphasised by Duhring as specially common sites—namely, "the neck, chest, back, abdomen, upper extremities and thighs." "The irregularity in size and form of the vesicles," "their firm, tense walls," "their herpetic character," and the considerable pruritus, singled out for special mention in that paper, were conspicuous here. As regards the sex and age of this patient, in a series of twenty-four cases described by Meynet and Pehu,[1] occurring in children, the following conclusions were drawn by these authors: (1) The later years of childhood were more subject than the earlier, especially between the ages of 6 and 10; (2) seventeen out of the twenty-four cases occurred in males. The exhibitor had shown at the Dermatological Society of London a case with very similar distribution in a female child aged 3,[2] who had been under his observation with repeated attacks of the disease for several years. He had also reported another case in a little girl,[3] and Gardiner[4] had described a series of four cases occurring almost simultaneously in female children under 9 years of age. But the disease was undoubtedly much commoner in male children.

[1] Meynet and Pehu, *Ann. de Derm. et de Syph.*, 1903, 4me sér., iv, p. 893.

[2] *Brit. Journ. Derm.*, 1903, xv, p. 409.

[3] *Ibid.*, 1902, xiv, p. 425.

[4] *Ibid.*, 1909, xxi, p. 237.

Case of Epithelioma of the Right Thigh.

By E. G. Graham Little, M.D.

The patient was a woman, aged 64. This case had been described in a recent paper read before the Harveian Society by the exhibitor as an instance of rodent ulcer, but the character of the ulcer was so peculiar that he had changed his opinion and had come to regard it as a possible example of Paget's disease, under which designation it was shown at the meeting. A microscopical examination had, however, now established the diagnosis of rodent ulcer, with some unusual features. The site was one of the most infrequently recorded. In a wide review of the literature the exhibitor had been able to find only one other example of rodent ulcer in the same situation.[1] The appearance of the ulcer was also atypical; there was absolutely no hardened edge, the surface presented a velvety red aspect which the nurse in charge of the case had aptly described as "like a tomato, cut across," and there were some islands of epidermisation scattered over this surface which had suggested the diagnosis of Paget's disease, this feature having been much insisted upon by the French school as a characteristic of that condition. The ulceration was now about 2 in. by 1½ in. in size. There was a history of a pigmented mole, present from birth, having occupied the site of the ulceration, and having remained unaltered until about three years ago when some injury had abraded the surface and ulceration had slowly proceeded from this centre. No enlarged glands could be felt in the groin. The whole affected region was removed by operation, and microscopical investigation of some of the excised tissue revealed typical rodent growth.

[1] Bidwell, *Brit. Journ. Derm.*, 1895, vii, p. 265.